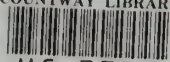


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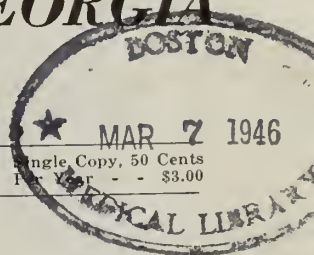


# THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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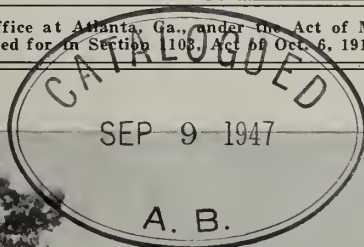
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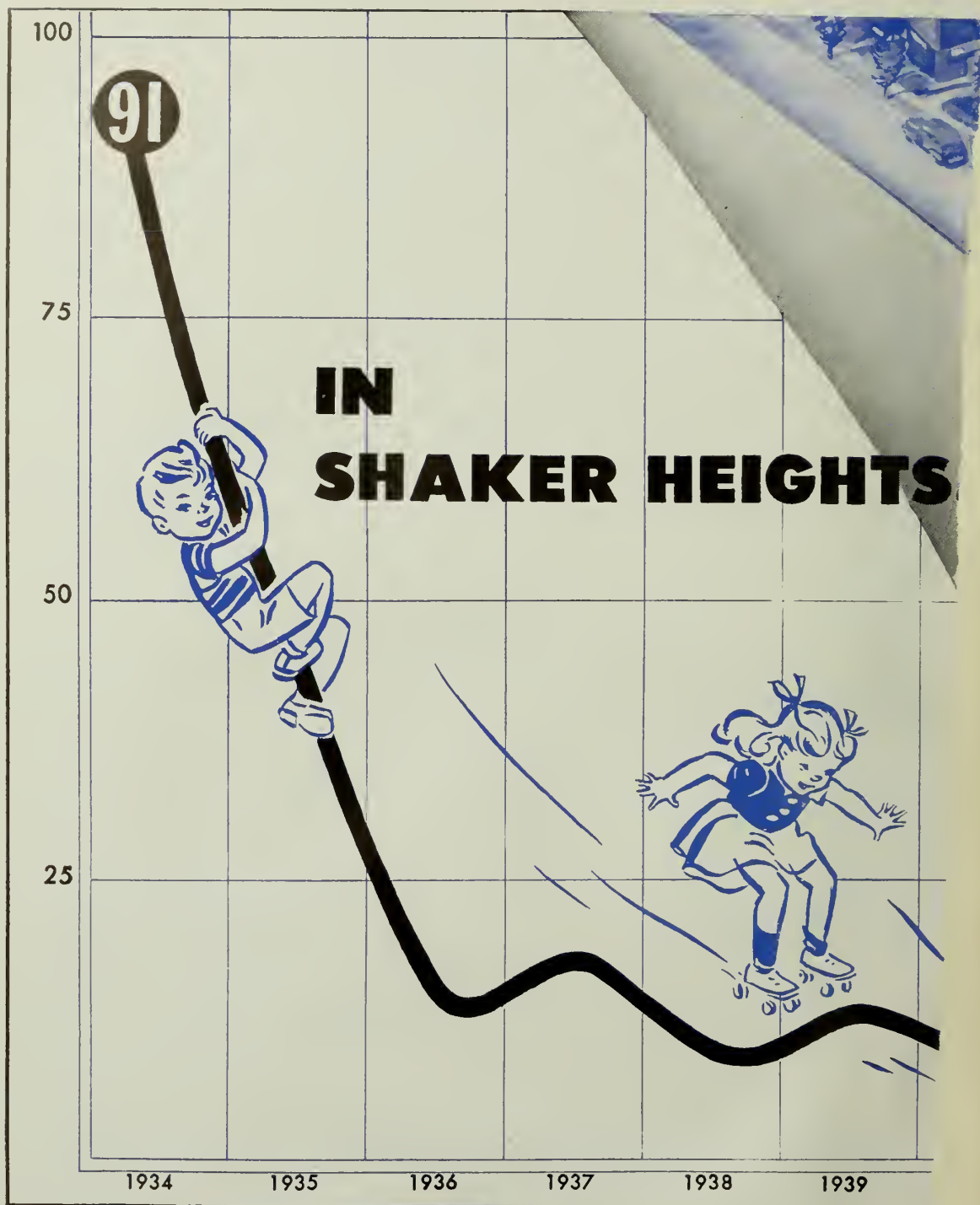
FOR NERVOUS AND MENTAL DISORDERS, DRUG AND ALCOHOL ADDICTIONS

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VOL. XXXV

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Number 1

### PREVENTION AND TREATMENT OF PULMONARY EMBOLISM

J. GASTON GAY, M.D.

W. H. PROCTOR, M.D.

*Atlanta*

The study of pulmonary embolism has been painfully slow and baffling in comparison to other conditions besetting the surgeon. Small emboli occur much more commonly following surgical operation and are much more frequently overlooked than we care to believe. The early symptoms of thrombophlebitis, which have begun to be called thrombo-embolic disease, are all too frequently passed over as inconsequential. Then, when the rapidly fatal massive pulmonary embolus occurs in an otherwise uncomplicated surgical procedure we are much too apt to accept it as an act of providence and go on to the next case, feeling that we have done all we could. In the light of more recent studies on thrombophlebitis, this position appears no longer tenable and it is with this idea in mind that this paper was undertaken.

The incidence of pulmonary emboli in relation to superficial thrombophlebitis is stated by Barrow and also Nobl to be 0.5 per cent of all fatal emboli. On the other hand in thrombophlebitis of the deep veins, the incidence of all emboli, according to Welch and Faxon is 1 in 3, but of this number only 5.5 per cent suffered fatal emboli. The above incidence is also directly affected by the age of the patient. In the above group studied by Welch and Faxon, of 53 patients under 50 years of age, 15 had some form of emboli or 28 per cent; of 56 patients in the age group of 50 to 70, 16 had emboli, or 31 per

cent; of 10 patients over 70, 4 had emboli, or 40 per cent. Therefore, there appears to be a definite increase in the number of emboli with advancing age.

The occurrence of fatal emboli in deep phlebitis in relation to age is even more striking. It is extremely low below 50, while from 50 to 70 it is 7 per cent and 20 per cent over that age.

From the above figures it becomes evident that if early diagnosis could be made and preventive measures instituted while the process involves only the superficial veins, the mortality would be 0.5 per cent. If the process is allowed to extend to the deep veins, particularly in the age group of 50 to 70, mortality is from 7 to 20 per cent.

A study of the pathology of thrombophlebitis is even more striking. Formerly the uterine and prostatic plexus of veins were considered to be the main source of fatal emboli. This view is now believed to be incorrect. A study of autopsy reports during this period shows no examination of the veins of legs. When this is adequately done it is apparent that the large fatal emboli usually originate from the large veins of the lower extremities. Prettin found that 133 out of 144 fatal emboli originated from the region drained by the inferior vena cava. Ninety-one of the patients had involvement of the femoral or iliac veins. Hampton and Cattleman have observed that a very large percentage of emboli arise from symptomless thrombosis of the deep veins of the legs, usually in the calf or popliteal region. Cattleman further states that with the exception of pulmonary emboli originating from the heart, 95 per cent of all fatal emboli arise from the veins of the lower extremities, i.e., from the veins of the calf to the iliacs. This is attested by the fact that he has found the source of emboli in the legs in

From the Department of Surgery of Grady Hospital, Atlanta, and of Emory University.

all but 2 cases in which he has done an autopsy.

In the light of these pathologic findings, the following theoretical sequence of events takes place in pulmonary embolism. Thrombophlebitis which is frequently symptomless starts first in the veins of the calf of the leg, extends either in the deep venous circulation of the calf, or superficial circulation, then extending upward by propagation along the deep veins through the common femoral and iliacs to the inferior vena cava. At any point during this process, and especially if the clot is propagating and attached only at a lower level and freely waving in the circulation, a portion of the clot may be broken off and carried free in the circulation, thus producing a pulmonary embolus. It has also been more or less proven that this type of freely waving clot in the deep veins of the lower extremities is the most dangerous as regards pulmonary emboli.

With the above sequence of events in mind, it can readily be seen that the lower this process is interrupted in the smaller vessels of the calf or below Poupart's ligament the less likelihood there is of pulmonary embolism. This postulate is further strengthened by the very small incidence of pulmonary embolism in superficial thrombophlebitis and the rapid increase in deep phlebitis. Therefore, treatment should be instituted early in an attempt to forestall extension of this process, thereby blocking completely the source of the emboli.

### *Diagnosis*

In order to make an early diagnosis and institute treatment at a time when it will be of most value it has been found to be much more important to locate the area of the vein involved in the pathologic process. This means that either the deep or superficial veins should be suspected as the site. Frequently deep phlebitis extends to involve all or a part of the superficial system, while the reverse is occasionally true.

Clinical differentiation as to the extent of phlebitis is often difficult. Superficial phlebitis is relatively easily diagnosed by the presence of painful, tender subcutaneous thrombi along the course of the sa-

phenous vein but detection of deep phlebitis may be very difficult.

Careful examination of the leg may show slight tenderness in the calf or swelling of one leg. Homan's test of pain in the calf on forcible dorsiflexion of the ankle is occasionally positive when other tests are absent. Edema of the lower leg usually means thrombosis of the popliteal and lower portion of the femoral vein. Edema of the thigh indicates that thrombosis extends at least as high as the external iliac vessels.

Laboratory methods such as the white count and sedimentation rate are so variable as to be of little value. Welch and Faxon state that the only value is that a return to normal usually accompanies clinical improvement in the phlebitis.

Since most of the above methods are to a great extent inaccurate, venography as developed first by Dos Santos and later elaborated by Bauer and Homans probably offers the most accurate method of locating the site of the pathologic process. This requires an accurate technic and a complete familiarity of the reader of the plates in order to interpret it correctly. This technic is still in its infancy but after further study may offer the most accurate diagnosis.

In order to evaluate the severity of a case of thrombophlebitis and determine when it has ceased entirely, pain, edema and the amount of associated arterial spasm all offer some means of comparison but are variable. Welch and Faxon have suggested these criteria which seem of value:

1. Duration of elevation of temperature which they consider to be of limited value because some cases show no elevation.
2. Occurrence of pulmonary emboli during the acute phase.
3. Chronic edema. This last is hard to evaluate on account of the difficulty in following these patients.

### *Treatment*

Treatment of thrombophlebitis with the idea of prevention of pulmonary embolism may be divided naturally into two large groups. First, superficial thrombophlebitis and second, deep thrombophlebitis. At this



point may we stress again the importance of the immediate institution of treatment of whatever type may be necessary as soon as the diagnosis is made.

Superficial thrombophlebitis may be treated in either of two ways. Ochsner and DeBakey, using procaine hydrochloride for lumbar sympathetic block, have reported excellent results. In our experience the results have been dramatic and the duration of the phlebitis greatly reduced, but it is frequently necessary to do repeated blocks. On the other hand, ligation and resection of the saphenous vein either at its entrance into the popliteal or femoral gives the same dramatic relief of pain and swelling with the added sense of security that the thrombosis will not enter into the deeper veins. Furthermore, it frequently gives the surgeon the opportunity to examine the deeper veins for thrombosis.

Treatment of deep phlebitis is considerably more complicated. The importance of early diagnosis of this condition and immediate treatment as a preventive measure against pulmonary embolism cannot be overemphasized.

For purposes of clarity we will divide deep thrombophlebitis into two groups.

1. Cases uncomplicated by emboli.
2. Cases complicated by emboli.

In the first group, prolonged heat, elevation of the legs, compression bandages and complete bed rest in conjunction with parasympathetic block as popularized by Ochsner and DeBakey are used. The theory involved here is that a localized area of thrombophlebitis causes vasospasm, the blood flow is reduced, metabolites collect in the tissues and edema develops. Proper sympathetic block with the other methods described if instituted early, should relieve the vasospasm and clear up the condition.

All of these patients should be considered potential emboli producers and therefore it has been suggested that dicumeral be used early in the disease.

The second group in which emboli have occurred presents a more difficult problem.

Three methods of treatment have been used in this hospital:

1. Dicumeral.
2. Ligation of deep veins of the leg.

### 3. Ligation of the inferior vena cava.

1. Dicumeral. We have had considerable experience in the use of dicumeral and find it an excellent drug. Rather glowing reports have come of its use at the Mayo Clinic where 180 cases of pulmonary embolus have been treated with only two deaths. These results are certainly excellent and in our opinion the drug rates a high place in the treatment of pulmonary embolus.

It has the following disadvantages for general use. A. It requires daily prothrombin time determinations and to be effective requires that the prothrombin time be kept between 15 and 20 minutes. Therefore, the patient must be carefully watched for hemorrhage and whole citrated blood transfusions given if they occur. All this requires adequate laboratory facilities. B. We have not been as lucky as the Mayo Clinic and have had several recurrences of pulmonary emboli and some deaths while the patient was receiving dicumeral therapy. Therefore, we believe that you cannot feel as secure about the results of treatment.

2. Ligation of the deep veins. This procedure has been employed in a small number of cases. It has been adequately described by Welch and Faxon, Homans and others. Its use in this hospital has been satisfactory in the vast majority of cases. We feel that, where the surgeon can be sure that the process does not extend above the calf, low ligation can be done; and that, when the process extends into the thigh below Poupart's ligament, the common femoral should be ligated, since we have had recurrence of emboli where it was done at a lower level. We also feel that the vein should be opened, the clot removed and the vein completely severed and ligated.

Since we have had recurrences of emboli from the other limb in which the vein has not been ligated and frequently there is no sign of phlebitis we have made it a rule to ligate both sides wherever ligation is done.

The swelling and edema in these cases has been moderate and well-controlled by compression bandages.

3. Ligation of the vena cava. This pro-

cedure has been carried out on 14 cases. It is reserved for that group of cases where we feel that the thrombotic process has extended past Poupart's ligament and where we feel that the general condition of the patient warrants abdominal operation. Eleven of these patients were operated upon by the abdominal approach while we operated on 3 by the retroperitoneal approach.

In the abdominal approach, a generous right rectus incision is done with its midpoint in the region of the umbilicus. The small gut is packed away into the right upper quadrant exposing the bifurcation of the aorta. A midline incision is then made in the posterior peritoneum about 6 cm. in length and the posterior peritoneal fat dissected carefully from around the vena cava, exposing it for a length of about 4 cm. above the bifurcation. It is then ligated triply with ties of heavy silk above and below and one tie of umbilical tape in the center. Closure of the posterior peritoneum is then done and the abdomen closed.

The retroperitoneal approach is on the right side and similar to that for unilateral sympathectomy.

Following this procedure we have seen only moderate swelling, frequently unilateral, and in some cases no swelling at all. This leads us to believe that the collateral circulation is adequate as you would expect from the anatomy of the region and that what swelling and edema we get is due to the pre-existing thrombophlebitis or disturbance of lymphatics, rather than from ligation of the vena cava. Some of the patients have been checked over a period of one year and show little or no swelling or edema. This is too short a time for complete evaluation of results. Therefore, we will make a complete report on these cases at a later date.

After ligation of the vena cava we can say that we have never had a recurrence of pulmonary emboli, and no deaths attributable to the ligation.

A fourth method has been suggested, namely, heparin therapy. We have had no experience with heparin therapy but some writers are optimistic. It is stated that heparin will not dissolve previously

existing white thrombi but will prevent extension of any thrombus. We have not used it because of its expense, difficulty of administration and reports of pulmonary emboli occurring after heparin therapy has been stopped.

### Summary

In summarizing all these methods of treatment we feel that each has its definite place. The condition of the patient should be completely evaluated and the proper treatment selected. The only indication for use of any of the operative procedures should be the definite diagnosis of one pulmonary infarct. We feel that when that diagnosis has been established, immediately the procedure best suited to the patient's condition should be instituted as time is of the essence in this condition.

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### MALARIA RELAPSE RATE DECLINING

The hospital admission peak for malaria relapses in the United States was reached in February 1945, with a total of approximately 6,000 cases, and has been steadily declining since that time, according to a recent announcement by the Army Medical Department.

During 1943, when men began to return from tropical theaters of operations in increasing numbers, the total number of hospital admissions for malaria relapse reached 5,275. By 1944 it had jumped to almost five times that number—28,150, and in the first six months of this year the total was 30,420.

It is believed, however, that the return of troops from malaria-ridden areas will not appreciably affect the downward trend of admissions, for a large proportion of original personnel already has been replaced and returned. Units and replacements sent to these Pacific-Asiatic regions after the middle of 1943 are not expected to show as high rates of infection as those of earlier groups.



## RENAL ECTOPIA

RUDOLPH BELL, M.D.

*Thomasville*

Renal ectopia is a congenitally displaced kidney which remains fixed in an abnormal position. The term should by no means be confused with that of renal ptosis or "floating kidney."

Fortunately, the incident does not occur in but one to 700 to 1,000 births. The anomaly is due to interference with the migration of the kidney during fetal development. Normally the embryonic structure remains in the bony pelvis until about the end of the eighth week of intrauterine life when it begins to gradually shift its position until it is opposite the first four lumbar vertebra. During its ascent the kidney acquires a blood supply from vessels more or less temporary in character, but in the abnormal condition the temporary vessels become permanent and fix the organ at whatever point such interference with migration may have taken place. Hence, the kidney becomes fixed to surrounding structures by adhesions, aberrant vessels and usually a very short ureter. One may have (1) single unilateral ectopy, (2) bilateral ectopy, (3) bilateral ectopy with fusion and (4) crossed ectopy with or without fusion.

### *Symptoms*

The predominating symptom of an ectopic kidney is pain. It is the variation and distribution of this symptom which is so unlike that of the normally located counterpart that merits attention. Because of the position of an ectopic kidney the pain is usually referred to the lower abdomen and suggests a low abdominal lesion in the male or a pelvic involvement in the female, all of which may lead to what appears to be a justifiable exploratory laparotomy. In some instances renal ectopia remains asymptomatic. Infrequently<sup>1</sup> an ectopic kidney blocks the birth canal and interferes with gestation and parturition. Disturbances in urination when accompanied by pyuria, demonstrable infection and hematuria are important symptoms, since these demand a complete urologic investigation.

### *Diagnosis*

Diagnosis is not difficult with the aid of urography, and information obtained by this means is more complete by the retrograde urologic investigation described by me.<sup>2</sup> The ectopic kidney may vary in shape as influenced by its surrounding structures. It may lie anywhere between the third lumbar vertebra and the hollow of the sacrum. In rare instances the condition has been found in the thoracic cavity and has been known to herniate through the inguinal canal.<sup>3</sup>

The chief differential points<sup>4</sup> in the diagnosis of renal ectopia from that of nephroptosis or "floating kidney" are: the abnormally fixed position of the kidney, alteration in its shape and size, the abnormal blood supply, the short ureter, usually an absence of renal fat, abnormal rotation of the kidney, and lacking complete formation of its calices. A differential diagnosis between renal ectopia and nephroptosis should always be made before making a surgical approach to the kidney for fear of hemorrhage by accidentally cutting one of the many abnormal blood vessels in the former condition<sup>5</sup>. There are great variations in the arterial and venous blood supply, both as to number of vessels going to the ectopic kidney and as to their origin. At times as many as six or more arteries enter the misplaced organ and they may arise from the aorta or above its bifurcation, or from the common or external iliac. They may arise on the side where the ectopic kidney should have been developed, or from the other side.

### *Treatment*

The ectopic kidney, if symptomless, should be left alone. In some cases the low abdominal pain and pyuria with the associated symptoms may be alleviated by ureteral dilatations as in case 2 here reported. In the more severe cases, where surgery is advisable, a nephrectomy is usually the operation of choice. Due to the short abnormal blood vessels and short ureter it is difficult to augment the position of the ectopic kidney. In extreme cases the position of the kidney and ureter can be improved by operation as was done in

<sup>1</sup>Read before the Medical Association of Georgia, Savannah Session, 1944.



my case 1. It is recommended that the approach to the kidney be transperitoneal, as it affords easy access to the kidney, permits ligation of blood vessels as they are encountered and minimizes danger to the larger vessels which may lie directly beneath the organ<sup>6</sup>. In some cases, however, the retroperitoneal approach may be done safely as was done in my cases 3 and 5.

#### CASE REPORTS

*Case 1—Crossed Left Ectopia with Fusion:* Miss J. M. R., a 20-year-old white girl, was admitted to the Archbold Memorial Hospital, Oct. 24, 1942, complaining of pain in the lower right quadrant of abdomen, which had been occurring off and on all of her life. During the exacerbations of the pain the symptoms resembled those produced by an acute appendicitis.

Five months previous, during an acute exacerbation, the appendix was removed but without relief of symptoms. The physician who removed the appendix stated that at the time of the operation he felt a retroperitoneal mass which he interpreted as being a kidney. Superficial examination revealed normal findings except for an area in the right lower quadrant of the abdomen which was suggestive of a pelvic mass. On digital rectal examination the mass could be better felt, and by bimanual palpation could be determined to be the size of a grapefruit.

The urine contained 1 plus pus, 2 plus bacteria (organisms of the colon group). The WBC was 6,250; RBC 3,880,000; Hb. 68 per cent. Polys 67, Eosin. 2, Mono. 1, Lymph. 28. No malaria.

Upon cystoscopy both ureteral meati were found in their normal positions. A No. 5 French catheter met resistance at approximately half the length of a normal ureter, on each side. The kidney specimens were negative to chemical and microscopic examination. X-ray films of the kidneys, ureters and bladder, with bilateral retrograde pyeloureterograms, revealed no evidence of calculi. The kidneys appeared to be fused and both were located to the right of the midline in a very low position. The calices of both kidneys projected mesially, which is characteristic of horseshoe kidneys. The ureters appeared very short. An intravenous pyelogram was then done to determine if there was a kidney on the right side. No evidence of kidneys was noted other than here described.

Under pentothal sodium anesthesia, and through a right low rectus incision, the kidney mass was exposed transperitoneally. The kidney mass was the size of a grapefruit and the shape of a uterus, the ureters being attached to each side of the kidney resembling the attachment of fallopian tubes to the uterus. There were three rather large short arteries leading from the abdominal aorta to the kidney. The ureters were stripped of some small bands, and the kidney was sutured to its adjacent fascia and peritoneum to immobilize it.

The operation, although done in more of an exploratory nature, has proved of benefit to the patient as there has been no return of the pain experienced prior to the operation.

*Case 2—Crossed Left Ectopia with Fusion:* K. H., a 20-year-old white boy, came complaining of backache and a slight throbbing pain in the right side of the abdomen. He was discharged from the Army because of these symptoms.

Urologic examination revealed the ureters to empty on each end of the ureteric ridge normally, and both kidneys to lie on the right side of the midline and extremely low in position, the left kidney being somewhat lower than the right. The calices of the kidneys extended mesially instead of laterally.

The symptoms were relieved by ureteral dilatation.

*Case 3—Unilateral Ectopia:* Miss E. S., a 19-year-old white girl, had had several attacks of severe pain in lower right quadrant of her abdomen. During one of these attacks she was prepared for an appendectomy, but on learning that the urine revealed pus the surgeon referred the patient for a urologic examination.

The right kidney was found to be fixed low in the abdomen on the right side. The pelvis of the kidney was at a level just below the iliac crest. The ureter looped upward above the kidney and was considerably dilated. The left kidney appeared normal.

Through a right Gibson incision the peritoneum was deflected and the kidney exposed. Numerous small blood vessels supplied the kidney, some of which were from the iliac vessels. The short blood vessels were ligated with difficulty and the kidney was removed extraperitoneally.

*Case 4—Mrs. F. D.,* a 37-year-old white woman, had had two normal pregnancies. She complained of a dull pain in the right side of the abdomen and a severe ache in the small of the back. A scout x-ray picture revealed a large right kidney shadow. Urologic investigation revealed two distinct pelvises of the large right kidney, each pelvis having a distinct ureter that opened in the bladder on the right side. There was no ureteral orifice at the left end of the ureteric ridge nor was there a left kidney.

This anomaly is very rare and it is interesting to note that an examination of the gastro-intestinal tract by barium meal and barium enema revealed the stomach and the colon to be entirely to the left side of the midline. The heart was on the left side and appeared to be normal.

*Case 5—Mrs. E. L. S.* was admitted to the Archbold Memorial Hospital March 20, 1940, six months pregnant and having chills and fever due to a pyelonephritis.

Three months before a diagnosis of horseshoe kidney, with an infected left side, was made. The condition responded to treatment by urinary antiseptics and ureteral dilatations.

On this admission to the hospital a marked dilatation was noted of the left kidney pelvis which contained 15 ounces of thick pus urine. Labor was induced and renal pelvic lavages were instituted. After several blood transfusions, renal pelvic lavages and supportive treatment, the isthmus of the kidney was divided and the ureter to the left kidney pelvis placed so as to be at the most dependent point for drainage. The operation was done extraperitoneally, and since dividing the isthmus and doing the plastic operation on the kidney pelvis this individual has gone through a normal period of gestation and parturition.

### Conclusions

1. Surgery on an ectopic kidney is more difficult than that of a "floating kidney" or nephroptosis.

2. Ectopic kidney with fusion is more prevalent than unilateral renal ectopia.

3. The anomalous position of the pelvic ureter and vessels accounts for the relatively high incidence of obstructive hydro-nephrosis in renal ectopia.

4. Pain is the predominating symptom in renal ectopia.

5. The pain is unlike that of renal origin and is likely to be interpreted as that caused by an acute abdomen.

6. An accurate diagnosis can be made by a complete urologic examination.

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## RENAL DECAPSULATION

ERNEST FELBER, M.D.  
*Atlanta*

I had the opportunity to see a female patient who allegedly had a number of years ago a normal kidney removed for intractable pain and who underwent again recently operations on the remaining kidney and ureter for persistent severe pain. Unfortunately, the operations did not bring the expected relief.

Considering this case and some other similar experiences, I thought it might be useful to call attention to a method which proved successful in many cases of intractable pain in the kidney without demonstrable disease in the kidney. I am referring to renal decapsulation. B. S. Abeshouse felt apparently the same urge and published recently a report of ten cases and an extensive review of the literature on renal decapsulation, which shall be quoted frequently.

It will be shown that renal decapsulation is not only indicated in cases usually attended by the urologist, but by the internist as well.

Renal decapsulation has been practiced widely for the past fifty years, but for some reason abandoned lately. Edebohls was one of the first to introduce renal decapsulation into kidney surgery. I cannot think of any other operation to be employed for more varying indications.

Abeshouse enumerates the following diseases of the kidney treated with decapsulation:

1. Acute glomerulonephritis.
2. Chronic nephritis (Bright's disease).
3. Acute or chronic (focal or diffuse) nephritis with pain or hematuria or both.
4. Nephrosis.
  - A. Degenerative.
    - a. Genuine lipoid nephrosis.
    - b. Pseudonephrosis (nephrotic stage of chronic parenchymatous nephritis).
    - c. Amyloid nephrosis.
    - d. Syphilitic nephrosis.
  - B. Toxic nephrosis.
    - a. Chemical (bichloride of mercury, etc.).
    - b. Eclampsia, post-abortion, bilateral cortical necrosis.
    - c. Drugs (sulfonamides).
    - d. Post-transfusion.
5. Acute pyelonephritis.
6. Chronic perinephritis.
7. Non-obstructive anuria (of reflex or secretory type).
8. Miscellaneous group.
  - a. Hypertension.
  - b. Chronic pyelonephritis.
  - c. Phosphaturia.
  - d. Orthostatic albuminuria.
  - e. Tuberculosis.
  - f. Cystic kidney.
  - g. Double kidney.
  - h. Black water fever.

It is almost generally agreed that the beneficial results of decapsulation are relief of intrarenal tension and improvement of renal circulation and secretion brought about by cutting and interrupting the vaso-constrictor nerve paths between capsule and renal cortex.

All of the above mentioned kidney diseases are usually associated with increased intrarenal tension or diminished renal secretion or both, and that is the reason why decapsulation is employed and is expected to bring curative effects. Disappointment with renal decapsulation was bound to come, when used without proper indication or too late after irreparable damage to the kidney had already occurred.



I believe that renal decapsulation has its place in kidney surgery and should be performed whenever increased renal tension associated with pain has to be relieved or impaired renal secretion has to be improved and medical treatment has proved ineffective. I reported in 1936 five cases of chronic perinephritis cured by decapsulation and wish to report three more cases. It is interesting to note that the previously reported five cases were young women aged between 17 and 25. Their chief complaint was a persistent pain in one kidney region and, in some cases, associated with slight elevation of temperature (99 to 100 degrees). The patients suffered for many months and underwent as a rule various treatments as diathermy, irradiations, etc., without benefit before proper urologic study and treatment were instituted.

The wrong assumption, that normal urine is exclusive for kidney disease was and is today partly responsible for the delay in the proper management of these cases. The diagnosis is difficult to make because urine examinations, cystoscopy, ureteral catheterization, and pyelography may not disclose the slightest evidence of disease.

There is only one reasonably reliable symptom, and that is filling the kidney pelvis with a non-irritating liquid like saline solution or sterile water in the amount of 5-7 cc., and the patient will experience severe pain in the affected kidney. The patient will identify the pain as an exaggeration of the pain he or she is suffering from. The kidney is very sensitive on palpation and slight pressure on the muscles covering the kidney, particularly on the back, will elicit a painful reaction. Differential diagnostic consideration has to be given to pathologic conditions in the retroperitoneal space, particularly to the glands there.

#### REPORTS OF CASES

*Case 1*—A woman 47 years of age, who gave the history of having had several operations for intestinal obstruction in years past, and right ureterolysis and nephropexy in 1938, was seen in November 1939 complaining of persistent pain in the right kidney region almost since her last operation in 1938.

The urologic study revealed: normal urine, normal kidney function on both sides. Excretory and retro-

grade pyelography showed a normal left kidney; the right kidney rotated 180 degrees so that the upper and lower poles were on the same level, the upper pole pointing toward the lateral abdominal wall and the lower pole toward the spine, the pelvis cephalad. Kidney pelvis and calices were slightly dilated. The kidney was palpable and very sensitive, but not movable.

The diagnosis of chronic perinephritis with displacement of the right kidney was made and decapsulation with correction of the malposition of the kidney was suggested. Operation was performed Nov. 21, 1939, at Emory Hospital in Atlanta. The right kidney was exposed as usual and found to be firmly attached to the peritoneum and all surrounding tissues by dense adhesions. The thickened, hardened, fatty capsule had to be incised before the true capsule could be reached. The kidney was decapsulated and the capsule used to suspend the kidney in correct position on the last two ribs. Convalescence was uneventful and the patient has been well since.

*Case 2*—A male patient 36 years of age was seen in December 1943, complaining of persistent pain in the left kidney region for the past year. Urinary infection was supposed to be present at first, which was cleared up with sulfanilamide, but the pain remained. Medical treatment did not relieve the pain. Complete urologic study was negative except for identification of the pain by filling the kidney pelvis. Operation was performed on Dec. 23, 1943, at St. Joseph's Infirmary in Atlanta, and consisted of exposure of the left kidney, freeing of the kidney from dense adhesions and decapsulation. On the lower pole between the true capsule and the kidney cortex a small lipoma the size of a pea was found and removed. Convalescence was uneventful, and the patient has been free of symptoms since the operation. Whether the lipoma caused the pain by irritating the nerves between the capsule and kidney or the perinephritis, or both, is hard to decide.

*Case 3*—An undernourished girl 21 years of age was first seen in 1943, complaining of pain in the left kidney region. Complete urologic study did not reveal any kidney disease except that the patient identified the pain when the kidney pelvis was filled with only 5 cc. of sterile water as the pain she always had.

The kidney was palpable and sensitive, but by no means ptotic. The physical examination revealed slight anemia and fever, ranging from 99 to 99.6. There were no signs of tuberculosis.

It seemed advisable to improve the general condition of the patient and to try to give her some relief by internal medication, diathermy, etc. The general condition improved, but the pain in the left kidney became more severe; she suffered day and night. Under these circumstances surgery was advised and exposure of the left kidney performed on Dec. 4, 1944, at St. Joseph's Infirmary in Atlanta. An unusual rich vascularization of the subcutaneous tissues, muscles, and perirenal fat was noticed. The thickened fatty capsule, firmly attached to the kidney, was separated from the capsule and the kidney decapsulated. Convalescence was uneventful and the patient freed of pain.

The underlying disease in nonsuppurative cases of perinephritis is rather the end



result of inflammation than inflammation itself. The perirenal fat is thickened, firm adhesions are formed and in excessive cases constricting sclerosis may be observed. The source of perinephritic inflammation is not easy to determine; repeated urinary tract or metastatic infections may be the etiologic factor.

I employed decapsulation also in cases of oliguria and anuria with satisfactory results.

Abeshouse reviewed 2,298 cases of renal decapsulation and states that 100 per cent success has been attained in cases of chronic perinephritis, which is in agreement with the results in the reported cases.

But far more difficult is the evaluation of decapsulation in various forms of nephritis, nephrosis, pyelonephritis, and eclampsia, because one is dealing with seriously ill patients, who as a rule, and rightly so, underwent medical treatment for long periods of time, and only alarming symptoms may induce the internist to call for surgical intervention. In general anuria, progressive oliguria, rising blood pressure, increasing edema, pain and hematuria not relieved by conservative measures are indications for an attempt with renal decapsulation. Early operation is essential in cases of anuria or progressive oliguria. Where irreparable damage to the kidney exists decapsulation is useless. Decapsulation is only a supportive measure to improve circulation and secretion of the kidney.

According to reports quoted by Abeshouse, many a life has been saved by properly indicated decapsulation when internal treatment failed. Whether unilateral or bilateral operation is employed depends largely on the severity of symptoms and the condition of the patient. Renal decapsulation is a simple operation almost without risk involved, requiring hospitalization from 8 to 10 days.

#### *Summary*

The purpose of this paper is mainly to call attention to an almost forgotten but nevertheless very useful kidney operation which proved very successful not only in the reported cases of nephralgia but also in various kidney diseases, if properly indicated.

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## THE USE OF LANATOSIDE C IN THE TREATMENT OF CONGESTIVE HEART FAILURE

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In recent months the new drug lanatoside C has received wide experimentation and clinical evaluation. The object of this paper is to review the literature concerning this drug; but first, a brief pharmacologic review of digitalis will be given so that a fair comparison may be made between the new and the old.

In 1785, William Withering, master physician of Birmingham, England, published his classic book "An Account of Foxglove and Some of Its Medicinal Uses." Though foxglove, or digitalis at its crudest, had been used since antiquity by herb doctors, it was after Withering that a more rational application was made of this drug. After more than a hundred years of use and more or less abuse, digitalis has emerged as the drug of choice for the treatment of congestive heart failure and certain cardiac arrhythmias. Nevertheless, though digitalis is considered either much better or much safer by the medical profession than strophanthin, ouabain, squill, etc., it is by no means completely therapeutically satisfactory; therefore, a wide search has been made for a better substitute.

The<sup>1</sup> active principle of digitalis and allied drugs is the glycoside, which is found in combination with a saponin — this saponin being inactive therapeutically. Each glycoside is a combination of an aglycone with one or more molecules of sugar. The pharmacologic activity is lodged in the aglycone, but the attached sugars are thought to control water solubility, cell permeability, and persistence of cardiac action, thus the potency of the drug. The sugars alone are inactive, but they may be

compared to the ethyl in gasoline — they add to the smoothness and power.

This complicated chemistry of the aglycones has been only partly worked out. In most cases the basic formula is  $C_{23}H_{34}O_{4.8}$ . *Digitalis purpurea* and *digitalis lanata* have similar glycosides, except that the latter has in addition lanatoside C which is not found in *digitalis purpurea*. Since our prime consideration here is with *digitalis lanata*, its chemical breakdown is given. As shown here, digilanid C is the same as lanatoside C, a pure glycoside.

compensation. However, slowing of the heart rate is not always a criterion for improvement of congestive failure — it can occur without a change in rate. In auricular fibrillation the vagal slowing factor and the direct action of the drug on the conduction of the heart act together. *Digitalis* also increases the refractory period of the auriculoventricular conduction.

By improvement in cardiac “tone” — whatever that is — *digitalis* is supposed to decrease the diastolic size of the heart.

In normal hearts *digitalis* decreases defi-

Source	Glycoside	Sugar	Aglycone
Digitalis Lanata	Digilanid A —(glucose — digitoxin (acetyl	3 digitoxose	digitoxigenin
	Digilanid B —(glucose — gitoxin (acetyl	3 digitoxose	gitoxigenin
	Digilanid C —(glucose — digoxin (acetyl	3 digitoxose	digoxigenin

The main action of *digitalis* is on the cardiovascular system, which responds differently to the drug in health and in disease. An analysis of the drug is complicated by the interrelated functions controlling the circulation, which may account for some of the divergent views resulting from experimental work. It is supposed that the glycosides enter the cell protoplasm of the heart muscle and release the active aglycone, but how the aglycone causes such a remarkable change in muscle activity, and in turn the clinical improvement, is just one of those unsolved mysteries.

In the main, the drug acts on the heart muscle fiber itself to increase the force of myocardial contraction. This causes the ventricle to empty more completely. Thus, the heart is capable of caring for an increased venous return, thereby lowering venous pressure. Diastolic filling is increased, especially if the heart rate is slowed; systolic time of the cardiac cycle is slowed. All in all, the mechanical efficiency of the heart is apparently increased.

*Digitalis* acts to slow the heart rate most likely through a reflex vagal effect manifesting itself through restoration of cardiac

nitely the cardiac output by a direct cardiotonic action of the drug. In failing hearts, however, the opposite is the result in that the output is increased. The heart is made more efficient as a pump both in respect to size and strength of contraction. Using experimental results found with dogs, some investigators propound that the primary action of *digitalis* is to pool blood in the splanchnic area and liver, thus relieving venous congestion on the right side of the heart — a “bloodless venesection” as it were. Blood pressure changes are secondary, and come about only through the changes in circulatory dynamics as manifested on the heart.

*Digitalis* is not a diuretic, and its effect on urine output is produced solely through its effect on the heart and circulation. As heart failure is relieved, venous congestion is reduced, and the increased hydrostatic pressure in the venous ends of the capillaries is lowered. The edema leaves the tissues and returns to the blood; thus there is first a hydremia and then a diuresis.

Now a review of lanatoside C. This drug is a pure crystalline compound — aglycoside of *digitalis lanata*.

The<sup>2</sup> therapeutic results of lanatoside C



have paralleled the best that has been obtained from digitalis. When given intravenously striking clinical effects were often noted in ten minutes, though full effect usually required one hour. A full digitalizing dose was needed to produce changes in the ventricular complex as shown on the electrocardiogram.

One investigator tried the drug both by oral and intravenous routes in congestive heart failure. As to clinical effectiveness no difference was found except that the intravenous form proved to be much quicker. Toxic symptoms were slightly more prevalent when the oral dosage was used. For maintenance therapy, it is evident that the oral form is more satisfactory.

After a single digitalizing dose of lanatoside C it takes two to three weeks for the EKG effects produced by the drug to disappear. This is the approximate excretion time of the drug, though there is some evidence that the excretion may last over a period of as long as five months.

In comparing digitalis and lanatoside C no significance objectively was found in the oral preparations. Patients who failed to respond to one drug failed to respond to the other. Patients digitalized with one could be maintained with the other. This holds good for both forms of lanatoside C.

The average digitalizing dose of lanatoside C is 1.6 mg. intravenously, orally 7.6 mg.; for digitalis 15 gr. Intravenous lanatoside C is absorbed or utilized four and seven-tenths times as much as the oral form. And the oral form three times as readily as digitalis in comparing maintenance doses.

The most obvious benefit of lanatoside C is from the intravenous use in urgent cardiac failure when rapid accurate dosage is desired. Its uniform potency and its purity allow greater confidence in giving large intravenous doses. It is a potent agent in congestive failure with normal rhythm, auricular fibrillation, and auricular flutter.

Another investigator<sup>3</sup> did electrocardiographic and clinical studies of lanatoside C and digitalis. Using the single dose method for both drugs he found that lanatoside C exerts its effect on the depression of the

RST segment eleven to twelve hours sooner than a comparable dose of digitalis. Clinical improvement was noted in the same sequence. With one dose of 15 grains of digitalis, 8 out of 20 patients showed toxic symptoms, while only 1 patient out of 20 showed mild nausea with lanatoside C.

Using controls, maximal RST changes occurred with lanatoside C in twenty-seven minutes, while it took an average of six and one-fourth hours for digitalis to produce the same result. With congestive failure, the pure glycoside produced maximal effect in two to three hours while with digitalis the same effect occurred eleven to twelve hours later.

In considering the intravenous use of lanatoside C in comparison with oral digitalis, Nicholson<sup>4</sup> states that digitalis takes too long to act, is too toxic in heavy doses for most people, and that nausea and vomiting are present in too many cases of congestive failure to get anywhere with trying to keep accurate doses. Lanatoside C does not change in potency as does digitalis.

LaDue<sup>5</sup> was one of the first in this country to bring out the clinical significance of lanatoside C. He found the intravenous digitalizing dose to be 1.6 mg., oral 6.25 mg., and oral maintenance dose 0.5 to 1.25 mg. In using the intravenous dose in congestive failure he found that 78 per cent with rates above 120 fell to 85 or less in two hours, and all were normal in seventy-two hours. In 15 patients a fall in pulse rate was noted in two to ninety minutes, with an average of thirty minutes. In the oral dosage the time was about twice as long.

In comparing the subjective feelings with lanatoside C and digitalis, the patients feel comfortable almost at once with intravenous lanatoside C; if the heart is fibrillating, it is controlled almost as soon. There is no statistical improvement in the objective signs. Only 4 of 117 patients showed any toxic signs.

Lanatoside C has a wide range of safety. Four patients given full digitalizing doses of lanatoside C were found later to have been previously digitalized with digitalis and on maintenance doses thereof. Only

## TREATMENT OF BURNS

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In modern warfare burns form quite a large proportion of the casualties, both among the personnel of the services and among the civilian population. Unfortunately, there is not universal agreement as to the best method of treatment for burns. It is not the purpose of this report to discuss the relative merits of innumerable agents and methods used, but it seems appropriate that certain observations and experiences gained in the care and treatment of burns overseas for the past three years should be presented. One method which has proven more satisfactory will be discussed and described. This decision was made because of the need to urge one form of local treatment, which is so simple that it can be understood and put into reasonably good practice by those having never treated a severe burn previously. By reporting personal observations in scores of second and third degree cases thus treated I believe information may be imparted to others which may favorably influence the care of severe burns in the future.

Heretofore, a cause of confusion and inadequate treatment was the assumption that one form of general or local treatment would satisfy all requirements. This has been found to be very erroneous. All burns should be individualized to do the most good; however, the method carried out in these cases, ranging from one to thirty days old, brought excellent results.

The adequate management of burns resolves itself about two main trends of thought: the general treatment of the patient and the local treatment of the burned area.

*General*—The prevention and treatment of shock was the first and most immediate consideration. This was facilitated by the relief of pain by morphine, fluids and plasma. Roughly, in the first twenty-four hours, 500 to 1,000 cc. of plasma was given for each 10 per cent body area burned. Subsequent dosage was based on repeated hematocrit and serum protein determinations. It was found that large amounts of fluids intensified edema, therefore glucose and saline solution were not given early in an amount exceeding the plasma, although fluids by mouth were given freely as long as the stomach was retentive. Whole blood transfusions were not given early but fairly frequently later. As soon as possible patients were put on a high caloric diet, rich in proteins, multi-vitamin tablets (2 t.i.d.) and ferrous sulphate (gr. 5 q.i.d.). Since the danger of contamination was so great and infection so common, practically all cases were given sulfadiazine (gr. 15 q4h.) routinely, and the concentration in the blood stream carefully watched. The regular giving

of narcotics and hypnotics is definitely contraindicated and not necessary as will be shown.

Due to the chronicity and long hospitalization of burns there is a natural tendency for these patients to feel sorry for themselves and to become depressed and discouraged. This can be and was overcome by a little extra effort and interest on the part of the nursing staff. Frequent short talks, discussions or some little special interest or favor for these patients, regardless of how trivial, brought surprising results in their mental attitude. Fulfilling the request of these patients, such as letter writing, greatly aids their morale.

*Local*—The local treatment was directed at immobilization of the burned parts to prevent further shock, the prevention and treatment of sepsis, and the prevention of contractures. In all cases burned surfaces were cleaned and treated as soon as compatible with the patient's general condition. Under strict aseptic precautions (attendants with masks, sterile drapes, instruments, etc.) the area surrounding burn was cleaned with soap and sterile water or saline (sometimes used directly on burned area), then the burned area was cleaned thoroughly, using boric acid sponges with a gentle rotary motion, being very careful to remove all encrustations, exudates, blisters, slough and loose shreds of skin and tissue, using scissors where necessary. This meticulous cleansing, though a rather long and tedious process when done correctly, is considered one of the keypoints in the final results. This procedure should not and cannot be rushed. That this "slow and easy" method is advantageous was further evidenced by the fact that practically none of these patients required morphine (except first treatment when anesthetic is usually necessary) or other sedation during or after dressings. Deeper tissue which appeared to be damaged was not debrided at once but secondarily in a few days, when necessary, after demarcation between healthy and necrotic areas had become apparent. The cleaned and debrided area is then dried gently with gauze and sprinkled lightly with sulfanilamide crystals.

Another cardinal principle follows; namely, the application of dry fine mesh gauze directly to the burned surface, even in the presence of slight superficial purulent drainage or infection. In none of these cases was vaseline gauze or other ointments used after the patient came under my care. Several thicknesses of gauze and abdominal pads were then put on and the whole dressing fixed by a firm pressure (elastic) bandage. Thick, firm pressure is another important step and should overlap the limits of the burned area since it limits absorption and prevents or minimizes the leakage of plasma from the damaged vessels to the surface and into the tissue spaces, thus largely controlling edema as well as supporting the burned area. The pressure



bandage should be applied as soon as possible, exercising care not to interfere with the circulation particularly about the head and extremities. Another essential is the matter of dressings. It has been found that too frequent changes do no good and often do harm, resulting not only in damage to regenerating tissue and greatly increasing the risk of infections, but also requires a tremendous amount of time on the part of the medical and nursing attendants. Unless there were excessive odor, fever, or purulent discharge, indicating rather severe infection, dressings were left in place 6-19 days. At the end of this period the deeper areas not healed or healing satisfactorily were found to be practically ready for skin grafting.

With the dry method the denuded areas never give the soupy appearance that is so common with vaseline or other grease gauzes, since the discharge penetrates through the plain dry gauze into the thick outer dressings. Removal of this gauze is easy and seldom requires the addition of saline. In over two years' experience overseas no better dressing was found than this simple one. That rapidity of healing, with a minimum of scarring and contracture, with this method has been remarkable is evidenced by the final results and disposition of over 175 consecutive cases thus treated.

Special mention should be made of burns of the face and hands. In the minor first degree burns of the face a mild boric acid, sulfadiazine or vaseline ointment with no dressing was used. In the deeper burns the same cleansing procedure, with the application of sulfa crystals and dry fine mesh gauze as described previously, was followed (no ointments in deep burns). Several layers of gauze were also applied and secured by gauze bandage. For additional pressure and holding gauze in place a six inch stockinette was used over the head with openings cut for the eyes, nose and mouth, with narrow strips of tape around these openings making the stockinette tighter and more secure. The top of stockinette was twisted and tied, adding to the pressure. At times, especially following grafting, an elastic bandage was also applied over all dressings.

Boric acid solution eye wash was used routinely every 3-4 hours. Two per cent butyn was also used when a patient had much pain, and at times continuous boric acid compresses to loosen and prevent encrustations on eye lids and lashes were used. Edema of the eyelids was an annoying complication. Moderate edema could be controlled by pressure dressings, but in some of the more severe cases with eversion of the eyelids, it was necessary to suture the lid margins together as was necessary before extensive grafts of the eyelids. On the lips the formation of "crusts and scabs" was considerably relieved and prevented by the free local use of plain mineral oil, and at times vaseline,

thus adding greatly to the comfort of the patient.

Burns of the hands were "cleaned, dried, sprinkled with sulfa crystals, and wrapped" as other burns, with the exception that each finger was covered with a thick dressing bandage individually and firmly using 3 inch gauze roll. Extreme care was taken so that the pressure was smooth and even and that the circulation was not retarded. The hands and fingers (in extension) were kept in this manner for 6-10 days. At the end of this time the flexor surfaces of the fingers were healed or well enough that the hand could be put in the best position of function, i.e., with the fingers slightly flexed over some type of splint. Future dressings do not require that fingers be wrapped separately, but firm pressure over hand and dorsum of fingers should be maintained. All burns of the hands and fingers were treated with the idea of grafting and starting motion at the earliest possible time.

In mildly infected cases the previously outlined procedure was followed, but in more grossly infected cases two methods were used: (1) Wet sterile saline dressings, changed every 2-4 days; (2) Daily bathing with sterile saline and mechanical cleansing of area, with dry dressings in between bathings. Penicillin was used with both methods, the latter proving more satisfactory, particularly in preparing cases for grafting.

Burns present fundamentally the same problem as do open wounds of any kind in regard to grafting, except that the areas are larger and are usually contaminated. It has been the rule to use split-thickness grafts within thirty days from the time of burning and seldom is it necessary to wait longer. These areas are prepared for grafting by excision of all dead tissue, daily bathing with sterile saline, and use of penicillin 3-4 days prior to operation. With penicillin protection, debridement of sloughing areas can be done early and a clean field obtained, saving time which would be spent in "cleaning up" of the wound. Here again dry fine mesh gauze has been used exclusively throughout the pre-operative and post-operative grafting period. Suturing the graft in place is necessary in less than 30 per cent of cases. To use plasma or other methods to hold the skin seems unnecessary when it becomes quite adherent by virtue of the wound plasma and fibrin within a matter of minutes when the area is "right" for grafting. Thin grafts spread out easily and soon become adherent and maintain satisfactory tension with proper pressure dressings.

In conclusion the treatment of choice, and of most success, is briefly summarized:

1. Appropriate treatment of patient's general condition in all stages.

(Continued on page 20)

# THE JOURNAL

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MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

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JANUARY, 1946

## DR. SHOULDERS TO LEAD BATTLE OF FREEDOM

There is a splendid timeliness in election of Dr. Harrison H. Shulders to presidency of the American Medical Association, for American medicine is facing the challenge of socialization, and Dr. Shoulders has been in the forefront of the fight against that hazardous challenge.

Leaders in the medical profession know the dangers invited by political control of medicine, however glibly its advocates dress it in words of innocence. As speaker of the AMA's house of delegates, and throughout his service in the Tennessee Medical Association, as member, secretary, and editor, Dr. Shoulders has led an uncompromising fight for the freedom of medicine from such political encumbrance, and he will bring to this new assignment the same unswerving defense of freedom's safeguard.

Dr. Shoulders will take office next year, but the fact doesn't abate the force of his immediate fight, and the American Medical Association's. They have mobilized for it; obviously are recruiting leadership of maximum stature, and command thereby the faith of the American public whose welfare is at stake. It is hardly likely that thinking American citizens will prefer political voices to authoritative, medical voices on a subject involving life and health. It is inconceivable that thinking citizens will permit subjection of MEDICINE to the principles of boondoggling, or assign it to the arrogant, untender mercies of bureaucracy.

Dr. Shoulders has earned the faith of his vast constituency, not only for professional skill, but for vision incorporating those standards and principles of medical freedom enabling American medicine to forge ahead in a field of science whose boundaries must remain beyond the reach of government dictation. As such a leader, his opinion will bear weight with the people. In this fight, his service again is to his country, no less than when he wore his country's uniform against another, external enemy.

The American Medical Association is to be congratulated for the choice of such a leader; Dr. Shoulders for the opportunity conferred; the country for possession of such leaders for the defense of principle at home.—*The Nashville Banner*, Dec. 6, 1945.

## EMOTIONAL DISTURBANCES OF VETERANS

There is much unwarranted generalization about the returning veteran. Some were never exposed to the privations of combat. Others have undergone the most trying hardships and have returned physically, emotionally, or mentally handicapped. Still others have returned physically and mentally the better for their army experience. Each returning service man must be looked upon as a distinct entity.

Re-adjustment to civil life is a problem to the majority. Many need help to adjust to the additional problem of physical or mental handicap. It must be kept in mind that many veterans were not well adjusted before entering the services. Without considerable help their adjustment now will be no better than that before induction.

We must help formulate the proper public attitude toward the veteran, assist him in finding his proper place in industry or other work, and help attain feelings of security and personal value which are essential to his well-being.

Unless properly placed, he is predisposed to develop feelings of inadequacy and insecurity. He should be accepted back in his former group and he should be given every opportunity to procure employment in keeping with his aptitude. Only in this way can he acquire a feeling of personal value and adjust satisfactorily. When he fails to acquire this feeling of personal value, the resultant feelings of failure or of inferiority may lead to undesirable reactions of a compensatory nature.

Psychologic motivation is due to a combination of causes, of which the least socially and morally acceptable possess the greatest driving force and are furthest removed from consciousness. That which to the patient is most easily acceptable, and is in the forefront of consciousness, is given as the cause of the reaction.

It has been found that the better integrated veterans suffer emotional changes in the direction of depression or elation combined with anxiety; the more poorly integrated react with hysterical symptoms.

Studies in cases of emotional disturbances in veterans frequently disclose a long standing anxiety over domestic affairs to which military service has merely served as a catalyst in precipitating a psychopathologic reaction. Real or suspected infidelity of a wife or fiancée is the most common precipitating cause; next comes illness or death of near relatives; then financial stresses. The danger of harm by enemy action has played a lesser role. The infidelity of a wife affects her husband's self-esteem, destroying its very center.

The reaction of the veteran depends much upon his intrapsychic personality structure. The healthy veteran, while adapting himself to his military task, looks to the future and plans for



peace-time goals. In contrast the maladjusted or inadequate veteran is more deeply affected by subjective values and is more exclusively concerned with himself. With his exaggerated egocentricity, he tends to preoccupy himself with the privations by which he is confronted. The degree of his self-absorption may be overwhelming.

To some, military service represented a danger. to others it meant an opportunity. To some the dependent subservient subordinate position of most servicemen signified a threat. To others it was a welcome form of security. For some, entry into the services was the starting point for certain regressive changes in the personality. intensification of dependent attitudes, and the surrender of responsibility to superior authority.

Among the predisposed personalities there have been observed two kinds of reactions: the temptation to escape from military life and the temptation to escape into it. Some have temporarily escaped tormenting conflicts relating to civil life by a plunge into military activity. Upon return home these conflicts frequently persist in an aggravated form.

The attitude of the veteran will depend to a large extent upon the attitude of his family and home community toward him. The family should take the attitude that while he may be temporarily mentally or physically incapacitated he is capable of re-adjusting himself.

The present system of compensation for disabilities, particularly nervous and mental, has certain faults. It is almost impossible for an individual with symptoms that have cash value to shake himself loose of them. In addition, if he receives much pity and pampering at home the likelihood of his recovery is still less.

Any one who has been away from home in service for one or more years, is going to find considerable re-adjustment necessary on his return. For the older men it may be a true return, in the sense that they are going back to something they have experienced before. For the younger man, who has grown up in the armed forces, adult civil life will be a new experience. Not only his work but also his home life will be something strange to which he has to accustom himself. The actual amount of adjustment will depend on many factors; it is likely to be considerable for many, particularly the psychoneurotic and the physically handicapped.

Many couples will find a return to married life a far from easy performance, however fond of one another they may be, and however faithful to one another they may have been during the time of separation. This will be more difficult in the case of the mentally and physically handicapped. On the man's side there will be the strangeness of domestic life with wife and children after years of living with men! His wife may have new ideas on living, to which he will either have to accustom himself or against

which he will have to fight. His children will have grown and they may not understand each other well at first.

For the woman there will be equal difficulties with the return of a man who has for years lived in a world entirely different from her own or from anything with which she is acquainted. Such difficulties will obviously be greatly accentuated where the long separation of war has led to estrangements, or where they have married in the haste of war and have to start their adjustment to domestic life for the first time.

The veteran should be treated as a normal individual. He should be loved and welcomed. If he returns with a disability, face it realistically. Focus on what is left; not on what is lost. Treat him as a normal, competent person; not as an invalid. Be patient and take time to get re-acquainted with him. Urge him but do not push him.

Many men were discharged from the services during convalescence and necessarily so as the services were geared for fighting and not caring for convalescents. If moodiness, belligerence, cynicism, or other mental symptoms persist professional help should be obtained. Faith in the veteran's ability to adjust successfully will do much toward helping him attain this goal.

If we are to escape the flood of criminal activity, marital maladjustment, and mental disease which followed the last armistice we must act now. The veteran should not find apathy on the part of the public. Decorated, acclaimed and beribboned by our government and our allies, the veteran is likely to come home expecting a most warm reception. Upon his return he will merit his full share of our material, gratitude and admiration. He will expect and be entitled to a decent job and economic opportunity and security. He will demand full recognition of his heroism and sacrifice from those from whom he feels it should be forthcoming. Unless he is welcomed with open arms by his family, friends, employer and community, there may occur an emotional let-down which could be easily expressed in resentment, hatred, and aggressive behavior.

The average soldier cut off from normal emotional outlets, and held in restraint by military law, will have a tremendous desire to indulge in liquor, easy living, and partying upon his return. If shunned or arrested the first time he staggers down Peachtree or some other street, he is most certain to react unfavorably and this may be the beginning of a long period of maladjustment. He should be given special consideration during his first six months to one year at home and not unduly frustrated until his various appetites have been satisfied.

We must take hold of the problem collectively and realize the great importance of every one of us in helping in this economic and domestic re-settlement of the veteran, particularly if handicapped. One of the greatest needs of these men



is for friends to whom they can turn for advice, sympathy, and encouragement while they are struggling with the problems of re-adjustment.

The worst battles one is called upon to wage in life are frequently those with oneself. The psychoneurotic and disabled veteran frequently struggles with feelings of inadequacy, inferiority, failure, uselessness and multiple and varied fears. Proper placement, and acceptance of the individual by those with whom he comes in contact, will assist in overcoming these morbid feelings and fears and in the development of an integrated, harmonious personality capable of attaining maximum efficiency, and maximum freedom from serious inner-strife.

The greatest majority of veterans with emotional disturbances are ambulatory and should be kept ambulatory and treated in their home communities. They frequently need financial tiding over until re-established. It might be well to give this help with the indication that it is for rehabilitation and not compensation for disability. There is some doubt as to the advisability of focusing the veteran's attention on financial settlement at the very time he is finding it difficult to get back into the life of the community. If this continues for any great period of time the veteran may begin to think of himself as a victim of war toward whom the government has a permanent responsibility.

Many men with emotional disturbances are leaving the services with the feeling that there is something physically wrong with them which the doctors have not yet discovered. They have had thorough examinations but these have been rather impersonal and the veteran has remained unconvinced of their thoroughness. It is probably the combination of waiting for the settlement of a claim and finding himself unable to work or hold down a job, which undermines the determination of the veteran to get back into normal civilian life.

Before V-J Day approximately 700,000 men were discharged from the services yearly for medical reasons; about half of these for psychiatric conditions. A large percentage of these had broken down during training, most of them within six months of induction. Many of their problems had existed prior to induction. Many men with conditions such as mental deficiency, psychopathic personality, epilepsy and chronic alcoholism had been inducted as their conditions were not recognized in screening. It is estimated that with more careful screening 70 per cent of these men might have been excluded.

Other countries came to similar conclusions. Records from the Royal Canadian Army Medical Corps reveal that of the psychoneurotics invalided out of the R. C. Army during the war, the majority were long standing cases who might have been excluded from the army with better screening.

It would be advisable that clinics be set up throughout the country where any person having difficulty in adjustment either because of war service or economic displacement might go for help. Every neuropsychiatric case in World War I cost the government about \$30,000. The advisability of early treatment is obvious. A bill has been recently introduced into the House of Representatives by the U. S. Public Health Service promoting a plan for grants-in-aid to the states to develop all-purpose mental hygiene clinics.

Treatment of emotional disorders of veterans is best accomplished by individual psychotherapy. Frequently short and superficial therapy is of considerable value. Such therapy is often the only therapy that can be given because of the time factor. Many cases, however, are in need of a deeper analytic type of therapy. The possibilities of group psychotherapy have much to offer.

HARRY R. LIPTON, M.D.

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#### ALL BUT 11,000 DOCTORS TO BE RELEASED BY NEXT JUNE

Army doctors are being released faster than the Army is reducing its total strength, in spite of the large number of battle casualties still remaining in hospitals and the requirement of doctors for separation center work, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently in New York in appreciation of the services rendered by member hospitals of the United Hospital Fund of New York.

"The peculiar situation that we find ourselves in is that demobilization, in which everyone is concerned, cannot proceed without the help of thousands of doctors—2,000 of whom are devoting their medical services solely to separation centers," General Kirk said. "By the first of January more than 14,000 doctors will have been returned to civilian life, which is more than one-third of the total number of doctors comprising the Army Medical Corps at its peak. By June of next year we anticipate releasing all but 11,000 doctors."

General Kirk, stating the peak hospital load in the United States to be 318,000, pointed out that there is still a need for medical personnel and that "one of our greatest problems is to hold enough doctors in the service to give the maximum medical care to our patients."

"I want to assure you," General Kirk concluded, "that, first, the Army Medical Department is going to continue to give to the sick and wounded soldiers of this war the best medical care known to science, and secondly, that it is going to return to civilian life as rapidly as possible every medical department officer whose services are not essential to the Army."

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**The Medical Association of Georgia will hold its next annual meeting at the City Auditorium, Macon, May 7-10, 1946.**

**GEORGIA DEPARTMENT OF PUBLIC HEALTH**T. F. ABERCROMBIE, M.D., *Director***THE RAW FACTS ABOUT OYSTERS**

Raw oysters as food should be considered potentially dangerous, especially if collected from contaminated waters, or if not handled under hygienic and sanitary conditions. Just as pasteurized milk is safer than raw milk so are oysters safer if cooked before being consumed as a food.

There are many biologic factors involved in the safety of raw oysters. This bivalve mollusk in the combined process of breathing and feeding filters many gallons of water in order to derive therefrom the minute drifting microscopic life and other matter which constitutes its food. In this process bacterial contamination if present in the water reaches the tissue surfaces of the oyster and thus may cause a highly contaminated food.

There are numerous records of cases of typhoid fever because of contaminated oysters, even to the extent of epidemics. In December 1924 an excessive prevalence of typhoid fever in Chicago was recognized by the city health department. A few days later the same was noted in New York City, Washington, D. C., and several other cities. After preliminary studies of many other sources of food and drink, suspicion turned from local sources to importation of food from some source common to each of these cities. After all other sources of food and drink were eliminated, attention was turned to seafood, particularly to raw oysters.

From the studies made by the city health departments of Chicago and New York it became apparent that a large majority of the cases were in persons who within the three or four weeks preceding onset of the illness had eaten raw oysters, and that besides oysters no common factor likely to be responsible in the spread of typhoid infection was in evidence.

On December 9, the health commissioner of Chicago issued through the local press and radio a warning to the people to refrain from eating raw oysters. On December 17 the health commissioner of New York City placed an embargo on oysters gathered in certain areas on the Atlantic Coast.

The aroused popular apprehension about the safety of oysters for food caused a very marked reduction in the oyster trade. The financial loss to the oyster industry was considerable.

The United States Public Health Service and the various states found it necessary to have a comprehensive study made of the whole situation so that definite conclusions as to the cause of the epidemic might be reached. Special investigations were conducted in cooperation with the state and local health departments immediately concerned, and with the Federal Bureau of Chem-

istry and of Agricultural Economics of the United States Department of Agriculture. The reports following the investigations made by the Public Health Service and the various state health departments afford conclusive evidence that incrimination of raw oysters was entirely justified.

It is quite evident from epidemiologic data obtained that contaminated oysters were obtained along a portion of the Atlantic Coast which were responsible for more than 1,500 cases and approximately 150 deaths. These studies included New York City, Chicago, Ill., Washington, D. C., and at least 10 other minor cities. From information gathered from the report there is indication that at least 70 per cent of the case histories showed that raw oysters had been consumed from such sources within 30 days prior to the onset of the illness. As usual in epidemiologic investigations the actual percentage would probably have been higher.

The report submitted by public health engineers and epidemiologists of these cases and reported in the bulletin of the Public Health Reports is most exhaustive and covers one hundred pages, including laboratory findings, sanitary and economic conditions, drinking water, dairy products, raw vegetables, and oysters. It was the unanimous opinion that to eliminate raw oysters from these sources as a causative factor it would seem necessary at least to prove that the oysters distributed from the source during the period of causation of the epidemic were entirely free from pollution with human excreta, either in concentration or in high dilution. This could not be done in face of the evidence. It seems one of the strongest cases in epidemiologic history.

As a result of such epidemics traced to contaminated oysters a conference composed of state health officers, sanitarians, representatives of the United States Public Health, and the oyster industry agreed that effective sanitary control of the industry required the following essential provisions.

Oysters should come from beds free, or as nearly as possible free, from pollution and disease producing organisms.

The condition of storage, handling and distribution should protect the food from contamination with pathogenic organisms and deterioration or adulteration.

Careful epidemiologic studies of disease outbreaks which incriminate oysters.

In order to express these provisions in a control program it became necessary that the respective states supervise the sanitary quality of waters over shellfish beds and designate only those from which stock may be taken, and also

(Continued on page 22)



## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1003 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, WALnut 8911; residence, JACKson 7979.

## NURSES LOSE FRIEND—DR. SANFORD PASSES

The death of Chancellor S. V. Sanford of the University System of Georgia was felt most keenly by the nurses of Georgia, especially by those who worked with him in his interest in the promotion of the centralized teaching program for three of Atlanta's hospital schools of nursing: the Crawford W. Long, the Georgia Baptist and the Piedmont, with the developments of the U. S. Cadet Nurse Corps. The base for the Department of Nursing Education was located at the University, in Athens, with all class room facilities and teaching personnel at the University System's Junior College in Atlanta for the cadet nurses of these schools.

Dr. Sanford's vision of including nursing education in the State's University was like that of Dr. Richard Olding Beard at the University of Minnesota when Dr. Beard promoted the first university school of nursing in 1908, in that both leaders in education were peers of their day and believed that young women who were to give understanding service to preventive and curative aspects of disease should have the best possible instruction in the humanities, biological, physical and social sciences. It was Dr. Sanford's conviction together with that of Dr. George M. Sparks and President Harmon Caldwell that the University of Georgia should take its place with other state universities in the preparation of nurses to meet civilian and military needs during the great war, and that it should plan to prepare teachers for schools of nursing, and later, a sound public health nursing program.

To this end, a year ago, a permanent program in nursing education was created in the University of Georgia. The organizational offerings in nursing are likened to those of the University of California in that their major campus is at Berkeley, and hospitals in Los Angeles. The University of Georgia's major campus in Athens and the University System of Georgia's Junior and Evening College serve basic students in nursing for three schools of nursing in the Junior College and many graduate nurses who begin their academic work in the Evening Col-

lege. The Athens nursing education program also directs a 4½ year program which includes affiliation arrangements with hospital schools of nursing for clinical nursing experience in some seven hospitals, and a teacher preparation program, all of which are designed to be of the greatest good to the needs of the people of Georgia.

It was during the last week of Dr. Sanford's life that he directed much of his efforts toward the improvements within the schools of nursing of the University Hospital in Augusta, and offered to the Hospital Authority an opportunity for a closer relationship between the Barrett School of Nursing and the University's Department of Nursing Education. This arrangement was made for the purpose of assuring a quality of nursing service to patients that would enhance the practical preparation of students in the University's School of Medicine in Augusta.

Dr. Sanford was held in high esteem by all of the nurses of Georgia for his understanding of their educational needs for nurses and nursing that would be of real practical value and will always be an influence to their preparation for satisfactory service to all mankind.

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## CARNEGIE LIBRARY OF ATLANTA—READER'S ADVISER'S DESK

*New Books of Interest to Nurses at the Carnegie Library of Atlanta*

*Brave Nurse*, by Ellsworth Newcomb (c. 1945). Fascinating true stories of the experiences of nurses in World War II. 940.547

*Essentials of Pharmacology and Materia Medica for Nurses*, by Albert J. Gilbert (c. 1944). A new edition of this comprehensive text and reference book. 615.1

*An Introduction to Medical Science*, by William Boyd (c. 1945). A detailed discussion of the causes of disease and the bodily changes which accompany it. 616

*The Romance of Medicine*, by J. A. Hayward (1945). The life stories of the great medical pioneers and their part in the development of medicine up to the present day. 610.9

*Yellow Magic*, by John D. Ratcliffe (c. 1945). The first comprehensive story of penicillin—how it was discovered and developed from the laboratory and test-tube

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## WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.

President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.

First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.

Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.

Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.

Corresponding Secretary—Mrs. Alex Russell, Winder.

Treasurer—Mrs. Ralph Fowler, Marietta.

Historian—Mrs. W. W. Puett, Norcross.

Parliamentarian—Mrs. Lee Howard, 625 East 41th St., Savannah.

Press and Publicity—Mrs. Charles Daniel, College Park.

### THE AUXILIARY STANDING IN A PLACE

"Give me a place upon which to stand and I will move the earth," said the philosopher.

Since creation women have been given places upon which to stand; as soon as the gates of Eden were closed to them they began training in sanitation, in their homes, in tents, in cliffs, in caves, in palaces, and taught their offspring that cleanliness was next to Godliness, for children bear the promise of a better world.

Time passed and the time came when a woman, Deborah, sat upon the judge's bench under the palm tree and held court in an open-air courtroom because of her purity, kindness and wisdom.

Hygeia, daughter of the physician Aesculapius, stood in a place advocating health for all mankind.

Florence Nightingale ministered with unwearied devotion to the suffering soldiers in the Crimean War.

So did Clara Barton in the Civil War, and Edith Cavell in World War I paid the death penalty because of her attitude toward health.

Madame Curie discovered the element, radium, by which the disease cancer is being stemmed and thousands restored to health.

Frances Willard worked against alcohol which destroys the best in the physical body.

On through the years women have been "weighed in the balance and not found wanting," for long ago they realized the necessity of being trained for the many tasks assumed; if not they would fail to do their part in helping to "move the earth" toward the betterment of humanity, especially toward a more healthy world.

Now we find them in every department of life, because they have demonstrated their ability when given free rein to use it. They have been given "places in which to stand."

And so has the Woman's Auxiliary of the Medical Society of the Sixth District, composed of three auxiliaries, Bibb, Baldwin and Washington counties, with a membership of 75.

War conditions, crowded homes and cities, and rationing of gasoline retarded all plans for the organization of new auxiliaries. Reports show that the organized ones have been alert. The members are busy in their places, promoting health, serving as chairmen and members of

various committees in all religious and civic organizations, advocating health in schools, in economic classes, in Parent-Teacher associations, missionary societies, Woman's Christian Temperance Unions, women's clubs, and all youth groups. Very active in the campaigns against cancer, tuberculosis, infantile paralysis and appendicitis, in distributing many pages of health literature, and securing 60 subscriptions to our official magazine, *Hygeia*, and to the National Bulletin.

Patriotic? Yes. Some are serving in the Army, Navy and Marines, others giving hours of valuable service in doctors' offices and hospitals. Some have given husbands and sons to fight for a democracy that will bring peace and health to all peoples. Thousands of hours given in Red Cross rooms that bandages and garments may be made and shipped on time. They are co-operating with the county health units, with and in all clinics. Visual education is being promoted through their offerings to health films and financial aid given to medical students.

The district meetings held in 1942 were outstanding. Dr. and Mrs. Coleman of Dublin entertained the June meeting at their lovely cottage on Coleman's Lake. Notable were the presence of state officers and past state presidents:

State President, Mrs. J. Lon King, Macon

State President-Elect, Mrs. Bruce Schaefer, Toccoa.

State Corresponding Secretary, Mrs. Wallace Bazemore, Macon.

State Treasurer, Mrs. Lucius Todd, Augusta.

Past State Presidents:

Mrs. Ralph Chaney, Augusta

Mrs. William Dancy, Savannah

Mrs. Lee Howard, Savannah

Mrs. S. T. R. Revell, Louisville

Mrs. Eustace Allen, Atlanta

Mrs. H. G. Banister, Ilia

Guest speaker, Dr. James A. Redfearn, Albany, State President, Medical Society.

The December meeting was most interesting and enjoyable in the beautiful home of Mrs. Ernest Corn, Macon, with guest speakers, Dr. Josiah Crudup, Macon, and Mrs. James N. Brawner, Atlanta.

Because of the war the medical society and auxiliary held no district meetings in 1943, but met all financial obligations and their delegates attended the state convention.

1944, President Roosevelt requested all medical organizations to continue the great program of health. The doctors felt and saw the need of keeping the health program before the public to give knowledge in how to prevent diseases and keep physically fit. They created new interest through letters, public addresses and meetings in which the auxiliaries participated.

The June meeting was held in the Dempsey Hotel; very few present due to many members away on vacations and husbands and sons home on furlough. However, forward plans were discussed and voted upon.

All letters have been answered promptly, reports compiled and mailed on time.

Today I close three years' service and the time has passed so rapidly it seems only a few weeks. It has been a pleasure to serve you, for you have been most kind, considerate and cooperative, and you have entertained us in your lovely homes, for all of which I thank you.

I wish we could have accomplished more but we feel that as members of the Woman's Auxiliary of the Sixth District Medical Society we have been given "places to stand" and are helping to "move the world" toward a more healthy world.

MRS. JAS. B. DILLARD,  
*District Manager.*

#### AUXILIARY NEWS

Mrs. H. M. Kandel was the principal speaker at the recent meeting of the Auxiliary to the Georgia Medical Society in Savannah. The meeting was held at the home of Mrs. J. K. Quattlebaum. As program chairman, Mrs. Kandel submitted a tentative program outline for the year which was approved:

October—Savannah's proposed Venereal Disease and T. B. Survey.

November—Legislation affecting the practice of medicine.

January—Medicine in the news.

February—Research in romance of medicine.

April—Annual report meeting.

June—Report from State Convention, Southern Medical and American Medical meetings.

Mrs. Charles Usher, budget chairman, submitted a tentative budget for 1945-46, which was adopted. A letter was read from Dr. H. F. Sharpley urging the auxiliary members to attend the meeting of the Chatham-Savannah Health Council to be held at the auditorium of Armstrong Junior College.

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Mrs. D. R. Longino, president of the Woman's Auxiliary to the Fulton County Medical Society, presided over the December meeting held at the Academy of Medicine in Atlanta. Mrs. Francis C. Beebe talked on the "Impact of Occidental Culture Upon China." Mrs. Beebe is national president of University Women and has spent

several years in the Orient. Mrs. M. T. Edgerton presented a short program on the Jane Todd Crawford Memorial.

Luncheon was served by the telephone committee consisting of the following: Mrs. Charles Daniel, chairman, and Mrs. T. F. Davenport, co-chairman; Mrs. J. G. Thomason, Mrs. K. E. Foster, Mrs. J. F. Arthur, Mrs. O. T. Malone, Mrs. Sam Green, Mrs. Charles Howard, Mrs. Charles Mashburn, Mrs. O. B. Bush, Mrs. W. R. Crowe and Mrs. W. W. Coppedge.

#### TREATMENT OF BURNS

(Continued from page 13)

2. Very thorough cleansing and debridement, with strict asepsis.

3. The use of dry fine mesh gauze. No vaseline or ointments (even on skin grafts).

4. Thick and firm pressure dressings, infrequently changed.

5. Early motion, and skin grafting.

#### NURSES' PAGE

(Continued from page 18)

stage to present-day commercial production. 615.3

*The Chemistry and Pharmacy of Vegetable Drugs*, by Noel L. Allport (1944). A text dealing with the derivation and properties of all the principal vegetable drugs. 615.32

*How A Baby Grows*, by A. L. Gesell (c. 1945). Dr. Gesell, well-known for his research on the behavior of infants and children, has given a graphic account of a baby's first year of life. 136.7

*Public Medical Care*, by Franz Goldmann (1945). The development of public medical care as a social movement from its beginnings to systematic planning and administration. 614.2

*Understanding the Child*, by Alfred Schrieding (1945). A new book on the child study written for the mother and those who work with young children. 136.7

#### ARMY SPECIALIZED TRAINING PROGRAM TO BE LIQUIDATED

Medical students now in the Army Specialized Training Program, which is undergoing gradual liquidation, will continue training through the current fiscal year, ending June 30, 1946, with the future of the program depending upon requirements for medical officers, which will be reconsidered at that time, according to an announcement by the War Department.

#### IMPORTANT ANNOUNCEMENT

Due to transportation difficulties the examination of the American Board of Ophthalmology, originally scheduled for Los Angeles, Jan. 29-31, has been changed to San Francisco, June 22-25, 1946.

1946 EXAMINATIONS: Chicago, Jan. 18 through 22; New York, April 10 through 13; San Francisco, June 22 through 25; Chicago, Oct. 9 through 12.



## THE USE OF LANATOSIDE C IN THE TREATMENT OF CONGESTIVE HEART FAILURE

(Continued from page 11)

one patient had any toxic symptoms — a transient nausea.

Experimental work being done by Drs. Stead, Merrill, Brannon and Warren, now in progress at Grady Hospital, Atlanta, has given us some controlled clinical observations on the action of lanatoside C. Using specially designed equipment these investigators make many observations — only a sample of their work is included here. Their work will be published in the future.

In all these cases 1.6 mg. lanatoside C is given in a single dose intravenously after control observations. Their next readings are taken one hour later.

### REPORTS OF CASES

*Case 1*—A 42-year-old woman in acute congestive heart failure had a pulse rate of 178, blood pressure of 96/76, right auricular pressure was 185 mm. of water, and the cardiac output was 2.3 liters per minute. One hour after receiving lanatoside C the pulse rate had fallen to 65, blood pressure was 135/73, auricular pressure 60, and cardiac output had nearly doubled — 4.5 liters. She was greatly improved subjectively, and she showed none of the signs of collapse noted one hour previously.

*Case 2*—A 54-year-old Negro man with hypertensive cardiovascular disease with acute failure was quite dyspneic and had Cheyne-Stokes respiration. Before lanatoside C, pulse 100, blood pressure 220/130, auricular pressure 200. After lanatoside C pulse 50, blood pressure 240/90, auricular pressure 100. Cardiac output not determined. Patient was considerably improved clinically; respirations were still somewhat irregular.

*Case 3*—A 73-year-old Negro man in acute failure and with auricular fibrillation with marked pulse deficit.

	Before Lanatoside C	One hour after Lanatoside C
Pulse rate	104	120 (and much more regular).
Auricular pressure in mm. water	250	230
Blood pressure	107/77 to 163/90	125/80 to 147/87
Cardiac output	5.6	5.6

Subjective change was marked—he was able to lie flat and sleep.

*Case 4*—A 53-year-old white woman in moderately acute failure with auricular fibrillation.

	Before Lanatoside C	After Lanatoside C
Pulse	134	92 and regular
Blood pressure	200/100	218/114
Auricular pressure	110	70
Cardiac output	5.6	8.2

At Grady Hospital we have used lanatoside C some seventy-five to eighty-five times in the last two years. Only the intravenous form has been used. Usually an initial dose of 0.8 mg. is given followed at four and eight hours with 0.4 mg. Thus a total digitalizing dose of 1.5 mg. It appears that 1.6 mg. of lanatoside C may be beneath the full digitalizing dose. In some cases a maintenance dose of 15 grains of digitalis is started the next day, in addition to lanatoside C. As in all drugs, the dosage must be given according to the patient. This is the usual routine employed in acute congestive heart failure. On occasion the drug has been given intramuscularly along with digitalis. In a number of cases of extreme distress, the total digitalizing dose has been given at one time. Toxic symptoms have been negligible.

Lanatoside C has also been effective with paroxysmal auricular tachycardia refractive to no other method, acute pulmonary edema, and in eclampsia of pregnancy. The number of cases here is small.

In conclusion, the observations we have made on the use of lanatoside C at Grady Hospital seem to parallel the results obtained by other investigators. Its most striking effect is seen when it is used intravenously. Because of its uniform potency and purity, its rapid action, quick elimination, and excellent tolerance, we have greater confidence in giving it intravenously in the treatment of acute heart failure.

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*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*



## THE RAW FACTS ABOUT OYSTERS

(Continued from page 17)

to supervise the sanitary collection, storage, handling, marketing and distribution of the oysters followed by certification by the state in co-operation with the United States Public Health Service before such oysters would be permitted for interstate shipments.

For obvious reasons the work in Georgia was placed under a different state department than the Department of Public Health; this, of course, did not invest authority in the Health Department, nor was such department responsible for the certification or non-certification of interstate shipments of oysters.

Later the oyster industry together with the State Department of Game and Fish became increasingly interested in building up the industry and at the same time improving the sanitary quality of the Georgia oyster so that certification of interstate shipments could be provided.

Therefore, at the 1943 session of the Georgia General Assembly there were two legislative bills introduced and passed; namely, Senate Bill No. 75 and House Bill No. 339. Each of these bills, in addition to certain provisions for the State Department of Game and Fish, placed the sanitary control of oysters with the Georgia Department of Public Health, with authority to promulgate such sanitary rules and regulations as may be necessary to insure the sanitary safety of Georgia oysters and to meet sanitary requirements for interstate shipments.

After practically two years of intensive studies and investigations of the coastal waters of the State, involving bacteriologic sampling of the waters, the improvements in methods of collections and handling of the oysters, construction of new and improvements to old shucking houses, obtaining the confidence and respect of the oyster industry and other features, and in spite of the period of war making supplies, labor and equipment difficult to obtain, these efforts have been rewarded by such improvements in the sanitary quality of Georgia oysters that they are now generally being approved for interstate shipments.

If the oyster is made safe from contamination it has the following nutritional value. The oyster is a good source of vitamins A, B, and C. Seafoods contain larger amounts of iodine than land products or fresh water fish. According to the United States Bureau of Fisheries, oysters and clams contain about 200 times as much iodine as milk, eggs and beefsteak. Other minerals of great importance, such as calcium, phosphorus, manganese, copper, and iron exist in marine products in relatively large amounts. It is with pleasure that we can now recommend to the public Georgia oysters as excellent food, provided they are from containers showing that they are certified.

The oyster industry in Georgia should be developed into a growing state enterprise, and the quality and safety of Georgia oysters should place our State in competition with other coastal states.

L. M. CLARKSON, *Director*  
Public Health Engineering,  
Ga. Dept. of Public Health.

## NEWS ITEMS

The Crawford W. Long Memorial Hospital, Atlanta, obstetrical staff dinner meeting was held in the hospital dining room, December 5. Dr. Fred L. Adair, Chicago, spoke on "Uterine Rupture and Obstetric Errors."

Dr. E. B. Agnor, Atlanta, announces the re-opening of his office, 410 Medical Arts Building, Atlanta. Practice limited to internal medicine.

Dr. Cleveland Thompson, Millen; Dr. Ralph Chaney, Augusta; Dr. B. H. Minchew, Waycross; Dr. Olin H. Weaver, Macon; Dr. Allen H. Bunce, Dr. C. W. Roberts, Dr. James E. Paullin and Dr. Edgar D. Shanks, Atlanta, attended the Presidents' Conference and the American Medical Association House of Delegates' meeting in Chicago, December 3-6, 1945.

Dr. Hugh H. Barfield, Ocala, Florida, formerly of Atlanta, announces the opening of offices at 1317 South Orange Street, Ocala.

The Georgia Baptist Hospital and School of Nursing, Atlanta, staff dinner meeting was held in the nurses' home dining room, December 18.

Dr. Samuel Y. Brown, Atlanta, announces the re-opening of offices, 56 Fifth Street, N. E., Atlanta. Practice limited to obstetrics and gynecology.

Dr. Everett L. Eishop, Atlanta, announces his return to civilian practice after four years of active duty with the United States Navy and will be located at 204 Medical Arts Building, Atlanta. Practice limited to surgical pathology and consultation in tumor diagnosis.

Dr. Charles E. Upshaw, Atlanta, announces that Dr. Robert H. Gillespie is now associated with him in the practice of obstetrics and gynecology, 18 Fourth Street, N.W., Atlanta.

"The Doctors Talk It Over" is broadcast coast-to-coast over the Blue Network of the American Broadcasting Company each Tuesday evening and is presented by the Lederle Laboratories, Inc., New York City.

Dr. Milford B. Hatcher, Macon, announces the re-opening of his office for the practice of surgery, 430 Doctors Building, Macon.

Dr. Worth Hobby, Atlanta, announces the re-opening of his office, 605 Doctors Building, Atlanta. Practice limited to diseases of the chest.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, November 27. Paper: "Hydronephrosis in Soldiers Due to Obstruction at the Uretero-Pelvic Junction," illustrated with lantern slides, by Captain Harry R. Newman. Sta-

tion Hospital, Hunter Field. Due to the absence of Captain Newman, the paper was read by Dr. S. Elliott Wilson.

Dr. Sterling H. Jernigan, Atlanta, announces the removal of his offices to 57 Sixth St., N. E., Atlanta. Hours by appointment.

Dr. Carl C. Aven, Atlanta, was elected president of the Southern Chapter of the American College of Chest Physicians at their meeting held at Cincinnati, Nov. 12, 1945. The other officers elected were Dr. Paul A. Turner, Louisville, first vice-president; Dr. Herbert L. Mantz, Kansas City, second vice-president; and Dr. B. L. Brock, Waverly Hills, Ky., secretary-treasurer. This meeting was held in connection with the annual meeting of the Southern Medical Association.

Dr. William P. Leonard, Atlanta, announces the opening of his office for the practice of surgery, 312 Medical Arts Building, Atlanta.

Dr. Warren B. Matthews, Atlanta, announces his association with Dr. Mason I. Lowance and Dr. Eugenia C. Jones, 215 Doctors Building, Atlanta. Internal medicine, allergy and pathology.

First Lt. Gary E. Turner, M. C., A. U. S., Augusta, was among the 64 medical officers who recently completed the Aviation Medical Examiners' course at the AFF School of Aviation Medicine, Randolph Field, Texas.

The American College of Physicians will resume its annual meetings in 1946 and has chosen Philadelphia, May 13-17. Headquarters will be at the Philadelphia Municipal Auditorium, 34th Street below Spruce. The meeting will be conducted under the presidency of Dr. Ernest E. Irons, Chicago, and the general chairmanship of Dr. George Morris Piersol, Philadelphia.

Dr. Thomas J. Hicks, McCaysville, formerly of Copperhill, Tenn., announces the opening of his office at McCaysville for the practice of internal medicine and diagnosis.

Dr. Harry R. Lipton, Atlanta, announces the opening of offices at 573 West Peachtree St., N. W., Atlanta. Practice limited to psychiatry and neurology.

Dr. Marvin A. Mitchell, Atlanta, announces that he is re-entering the private practice of surgery upon the termination of services with the United States Navy; offices 478 Peachtree St., N. E., Atlanta.

Dr. John A. Bell, Dublin, having served with the armed forces for five years, including two years as commanding officer of a Station Hospital in England, has been discharged and has resumed the practice of medicine and surgery in association with Dr. E. B. Claxton, Claxton Sanitarium, Dublin.

The Bibb County Medical Society meeting was held at Ridley Hall, Macon, December 4. Annual business meeting and election of officers.

Dr. William H. Trimble, Atlanta, announces the re-opening of his offices, 478 Peachtree Street, N. E., Atlanta, for the practice of internal medicine.

Dr. John B. Varner, Atlanta, announces the opening of his offices, 1001 Medical Arts Building, Atlanta. Practice limited to obstetrics and gynecology.

Dr. Evans B. Wood, Daytona Beach, Fla., formerly of Atlanta, announces that he is limiting his practice to cardiovascular diseases.

The Sixth District Medical Society meeting was held at the U. S. Naval Hospital, Dublin, December 6. Program: Registration at hospital, tour of inspection, and luncheon. Scientific program conducted by members of attending staff of U. S. Naval Hospital. Business session and election of the following officers: President, Dr. J. A. Fountain, Macon; Vice-president, Dr. Charles Fulghum, Milledgeville; and Secretary-Treasurer, Dr. A. M. Phillips, Macon.

Dr. C. N. Walker, Jr., Adel, announces the opening of his office in the Corner Drug Store Building, Adel.

Dr. A. N. Galin, Brunswick, recently discharged from the U. S. Army, after nearly five years of service, has re-opened his office for the practice of medicine at Brunswick.

Dr. Henry C. Holliday, Athens, recently discharged from the armed forces, has resumed his medical practice in Athens.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, December 6. Scientific program included war medical experience of certain members of the Fulton County Medical Society: "Otorhinolaryngology," Dr. Lester A. Brown; "Infectious Diseases," Dr. C. W. Strickler, Jr.; "Neuro-Surgical Problems," Dr. Chas. E. Dowman; "Certain Problems in Aviation Medicine," Dr. Wadley R. Glenn; "Surgery in the Emory Unit," Dr. F. Kells Boland; and "Use of Whole Blood," Dr. Francis Parker.

Dr. T. A. Sappington, Thomaston, recently released from the U. S. Army Medical Corps, has resumed the practice of medicine at Thomaston.

The Emory Hospital Unit has received an official commendation from the commanding general of the Mediterranean theater of operations for the "high standards of professional service" rendered in that theater. "It is fitting to extend to Emory University and its School of Medicine," the citation, signed by Gen. Joseph T. McNarney, theater commander, reads, "commendation and appreciation of the 43rd General Hospital." Dr. Ira A. Ferguson, commander of the unit prior to its inactivation, on September 13, said that most of the officers, enlisted men, and nurses have now been separated from the service and are back in civilian life.

Shortly before V-J Day, Major Gen. Paul R. Hawley, chief surgeon of the European theater, cited the Emory Unit for performing its duties "with zeal and highest military discipline."

Dr. Marion Hubert, Athens, has returned home after serving nearly five years in the Army Medical Corps, and has resumed his practice at Athens.

Dean G. Lombard Kelly and the faculty of the University of Georgia School of Medicine, Augusta, have

been commended for their outstanding contribution to the war effort by Admiral Ross T. McIntire, Surgeon General of the U. S. Navy. The certificate of commendation will be framed and preserved in the archives of the school.

Dr. John P. Garner, Atlanta, has returned after two years' service in the Army Medical Corps, and will resume his medical practice in Atlanta. He will also take over his old position as assistant chief surgeon for the Atlanta and West Point Railroad, the Western Railway of Alabama, and the Georgia Railroad.

Dr. George J. Nicholson, Cornelia, formerly of Downey Hospital, Gainesville, has opened a maternity clinic at Cornelia.

Dr. William B. Quillian, Jr., Cartersville, recently discharged from the Medical Corps of the U. S. Army, announces the re-opening of his office at the Howell-Quillian Clinic, Cartersville.

Dr. J. E. Smith, Fitzgerald, has returned after serving in the Medical Corps of the U. S. Army, and has resumed the practice of medicine at Fitzgerald.

Dr. G. Lombard Kelly, Augusta, recently attended a meeting of the Association of American Colleges, Pittsburgh, Pa. The agenda for the meeting contained a number of topics related to the conduct of the medical school program in the post-war period. These topics included the return to normal peace-time schedules in the schools, and the reorganization of a program for interns, and the discontinuance of the V-12 program.

The Southern Medical Association held its thirty-ninth annual meeting in Cincinnati, November 12-15. The following officers were elected: Dr. M. Y. Dabney, Birmingham, Ala., president; Dr. Elmer L. Henderson, Louisville, president-elect; Dr. Lucian A. Ledoux, New Orleans, La., first vice-president; Dr. Oscar W. Frickman, Newport, Ky., second vice-president. Mr. C. P. Loran, Birmingham, will continue as secretary-treasurer. Past presidents' medals were presented to Dr. E. Vernon Mastin, St. Louis, Mo., and posthumously to Dr. Edgar G. Ballenger, Atlanta. Dr. Harold P. McDonald, Atlanta, at one time a professional associate of Dr. Ballenger, accepted the medal.

Dr. Robert L. Berry, Villa Rica, has returned after five years of military service, and has resumed the general practice of medicine at Villa Rica.

Dr. Wm. A. Hendry, Blackshear, recently discharged from the U. S. Army, has resumed his medical practice, and is associated with his father, Dr. T. G. Hendry, Blackshear.

The Muscogee County Medical Society meeting was held at Columbus, October 23. Preceding election of officers Dr. W. E. Storey, who has recently resumed his civilian practice following his separation from the Army Medical Corps, entertained the physicians with an account of his experiences in the European Theater of Operations, 1946 officers: Dr. O. D. Gilliam, president; Dr. W. E. Storey, vice-president; and Dr. J. M. Wilson, secretary-treasurer.

Dr. Chas. G. Jordan, Donalsonville, formerly of Sasser, recently discharged from the U. S. Army, joined the staff of the Donalsonville Hospital, and will be associated with Dr. Harry Baxley, Donalsonville.

Dr. Lee Battle and Dr. Edward Bosworth, Rome, the first two Rome physicians to enter military service, have been discharged and have returned to their practices at Rome.

Dr. W. Barron Crawford, Jr., Dr. Wm. E. Barfield, and Dr. Harry H. McGee, Savannah, have been released from the armed forces and have re-opened their offices at Savannah.

Dr. John R. Lewis, Canton, formerly of Louisville, has associated with Coker's Hospital, Canton, as resident surgeon.

Dr. L. W. Pierce, Waycross, has returned after serving in the Medical Corps of the U. S. Army for more than three years, and has resumed his practice of medicine, associated with Dr. W. F. Reavis, Waycross.

Dr. George R. Conner, Columbus, has returned after serving more than three years with the Army Medical staff, and has resumed his practice at 1229 Second Avenue, Columbus.

Dr. James A. Green, Jr., Athens, recently discharged from the Army Medical Corps, has opened his office at Athens to practice surgery.

Dr. Walter W. Kanter, Savannah, announces the opening of his office for the practice of medicine and surgery, 346 Bull Street, Savannah.

Dr. Charles R. Smith, Dawson, has been discharged from the Army Medical Corps and announces the opening of his office for the practice of medicine, Stewart Building, Dawson.

Dr. Rupert H. Bramblett, Cumming, was recently discharged from the U. S. Army, and is practicing medicine with his father, Dr. R. H. Bramblett, Cumming.

Dr. Albert Kelly, Savannah, obstetrician, talked to the Savannah Chapter of the American Society of Medical Technologists at their November meeting on the "Rh. Factor—Concerning the Blood's Reaction After a Transfusion."

Dr. Burch J. Roberts, Cornelia, recently released from the Army Medical Corps, will resume his practice of medicine at Cornelia.

Dr. J. Howard Hagan, Rockmart, formerly with the Chaudron Hospital, Cedartown, announces the opening of his office for the practice of medicine at Rockmart.

Dr. H. Homer Allen, Decatur, is the new president of the Emory University Hospital staff, succeeding Dr. William A. Smith. Dr. J. D. Martin, Jr., Atlanta, is vice-president; and Dr. Robert L. Whipple, Atlanta, is secretary.



Dr. C. E. Erwin, Warm Springs, chief surgeon of the Georgia Warm Springs Foundation, will head a special medical mission to Belgium. The mission will be sent by the National Foundation for Infantile Paralysis at the request of the Belgian Government.

Dr. Edgar Boling, Atlanta, was recently released from the Army Medical Corps, and has opened his office for the practice of surgery, 478 Peachtree St., N. E., Atlanta.

Dr. Max Mass, Macon, has returned after a year of work and study in Chicago, and has been appointed head of the x-ray and pathologic departments of the Macon Hospital, Macon.

Dr. T. J. Ferrell, Waycross, has returned after serving as surgeon in the United States Army for nearly two years, and has re-opened his offices at Waycross.

Dr. A. G. LeRoy, Tifton, recently released from the Army Medical Corps, after more than three years' service, has resumed his work with the Tift County health unit, Tifton.

The Southeastern Surgical Congress will hold its next assembly at the Peabody Hotel, Memphis, March 11, 12, 13, 1946. A number of prominent physicians will take part on the program. The medical profession is invited to attend the assembly. For information write Dr. B. T. Beasley, Secretary-Manager, 701 Hurt Building, Atlanta 3.

Dr. Tofey G. Smaha, Griffin, has been discharged from the U. S. Army, and has re-opened his offices at 108 North Hill Street, Griffin.

Dr. H. C. McGinty, Augusta, formerly of Statesboro, recently discharged from the U. S. Army Medical Corps, has opened his office in the Shirley Apartments, Augusta. Practice limited to obstetrics and gynecology.

Dr. R. B. Wilson, Atlanta, announces the opening of his office, 864 Juniper Street, N. E., Atlanta. Practice limited to neurology.

Dr. Irving L. Greenberg, Atlanta, announces his release from the United States Army and the re-opening of his office, 816 Grant Building, Atlanta. Practice limited to surgery.

Dr. Haywood L. Moore announces his release from the United States Army, and that he is re-entering the private practice of medicine, 204-205 Dunwoody Building, Brunswick.

The Fulton County Medical Society, Atlanta, recently elected Dr. T. P. Goodwyn, orthopedic surgeon, as president, named Dr. R. Hugh Wood as president-elect, and Dr. Calvin B. Stewart, vice-president. Dr. McClaren Johnson begins his second year of a three-year term as secretary-treasurer.

Dr. William Rawlings, Sandersville, recently discharged from the U. S. Army Medical Corps, announces he is connected with the staff of Rawlings Sanitarium, Sandersville.

## POSTGRADUATE COURSES EMORY UNIVERSITY SCHOOL OF MEDICINE

### *Internal Medicine:*

**January 14 - April 6, 1946**

### *General Surgery:*

**April 8 - June 29, 1946**

**(Twelve Weeks Each)**

These courses are intended to provide thorough study of the physiologic basis of symptoms and the newer methods of diagnosis and treatment. Instruction will be almost wholly in the form of clinics, conferences, and ward rounds in connection with the care of patients.

Emphasis will be placed on those problems most frequently encountered by the practitioner, but a wide range of subjects will be included.

The enrolment for each course will be limited to twelve. The work will not be offered unless there is a minimum enrolment of ten.

Other postgraduate courses will be organized from time to time, as the demand and need for them indicates.

**Address communications to:**

**The Dean**

**Emory University School of Medicine**

**50 Armstrong Street, S. E.**

**Atlanta 3, Georgia**

Dr. John Franklin McCoy, Moultrie, announces his release from the U. S. Naval Personnel Separation Center, and will be associated with Dr. A. G. Funderburk, Moultrie.

Dr. Ben S. Read, Atlanta, announces his return to practice, 710 Medical Arts Building, Atlanta. Practice limited to obstetrics and gynecology.

The Third District Medical Society meeting was held at the Windsor Hotel, Americus, Nov. 23, 1945. Program: "Socialized Medicine," Dr. G. Lombard Kelly, Augusta; "Physiology of Labor," Dr. Richard Torpin, Augusta; "Injoiner in Region of Hip Joint," Dr. Peter B. Wright, Augusta; "Use of Penicillin in Treating Diseases of Children," Dr. Phillip Mulherin, Augusta. Officers: President, Dr. Willis P. Jordan, Columbus; Vice-President, Dr. Herschel A. Smith, Americus; and Secretary-Treasurer, Dr. W. G. Elliott, Cuthbert.

Dr. Lamont Henry, Atlanta, announces the re-opening of his office, 35 Fourth St., N. E., Atlanta. Practice limited to internal medicine.

Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, Augusta, announces the return of all full-time members of the faculty, after absences due to service with the armed forces. These include: Dr. Robert G. Greenblatt, professor of experimental medicine; Dr. John H. Sherman, professor of surgery; Dr. Phillip Mulherin, professor of pediatrics; and Dr. W. A. Wilkes, assistant professor of pediatrics.

Dr. Preston DeWitt Conger, Moultrie, recently discharged from the medical corps of the U. S. Army, announces the opening of his office at Moultrie. He will be associated with Dr. F. M. Gay.

Dr. Harold W. Muecke, Waycross, has been discharged from the U. S. Army, and will re-open his office at 202 Folks Street, Waycross. Practice limited to diseases of infants and children.

#### OBITUARY

*Dr. John E. Christian*, aged 78, of Duluth, died Nov. 11, 1945. He graduated from Emory University School of Medicine, Atlanta, in 1893. Dr. Christian was a beloved citizen and physician of Duluth for many years. He was a member of the Methodist Church. Surviving are his wife, two daughters, Mrs. Irene Hasson, Calhoun, and Mrs. Bessie Studard, Berry, Ala.; a stepson, Mr. Frank Wilson, Atlanta; one granddaughter, Miss Nan Hasson, Calhoun. Funeral services were held from the Duluth Methodist Church, with Rev. J. Herman Allison officiating. Burial was in the church cemetery.

*Dr. Byron Daniel*, aged 70, Sardis, died Nov. 16, 1945. He was a native of Girard, a son of the late W. B. Daniel and Mrs. Mary E. Hills Daniel. Dr. Daniel graduated from the University of Georgia School of Medicine, Augusta, in 1900. He practiced medicine in Girard, Cordele and Sardis. He was a member of the Burke County Medical Society, the Medical Association of Georgia, the American Medical Association, and the Sardis Methodist Church. He is survived by two sisters, Mrs. Effie Daniel Peterson, Girard; Mrs. King Godbee, Sardis, and several nieces and nephews. Funeral services were held from the Bethlehem Baptist Church, near Girard, with the Rev. S. A. Douthit, pastor of Sardis Methodist Church, officiating. Burial was in the churchyard.

*Dr. James W. Payne*, aged 56, Monticello, died at his home, Oct. 30, 1945. He was the son of the late Thomas M. Payne and Nanie Persons Payne. Dr. Payne graduated from Emory University School of Medicine, Atlanta, in 1914, and was one of middle Georgia's well known and beloved physicians. He is survived by his wife, Mrs. Grace Phillips Payne; three daughters, Mrs. Charlie Cross, Douglas; Miss Carolyn Payne, Monticello; Miss Nan Payne, Boston, Mass.; and one son, Jim Payne, U. S. Navy. Funeral services were held at his residence, with the Rev. George D. Goddard of Milner officiating. Burial was in Williams Cemetery, near Bethel.

*Dr. Iron Clifton Power*, aged 69, of Hiram, died Nov. 16, 1945. He was graduated from Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1906. Dr. Power is survived by his wife, Mrs. Georgia Power, four daughters, Mrs. T. W. Barnard, Austell; Mrs. D. L. Crowe, and Mrs. Taft Owenby, Marietta; and Mrs. Roy Leggett, Hiram; three sons, S. A. Power, Hiram; E. B. Power, Austell; and I. C. Power, Jr., Marietta; two sisters, Mrs. Alma Castell, Cincinnati, and Mrs. W. L. Wilson, Marietta; and twelve grandchildren. Funeral services were held from the Sandy Plains Baptist Church, with the Rev. George V. Crowe and Rev. D. B.

Shellnut officiating. Burial was in the Sandy Plains Cemetery.

*Dr. Evan Otis Shellhorse*, aged 67, Dalton, died Nov. 19, 1945. He was graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1900. Dr. Shellhorse was a native of the Fairmount section where he began the practice of medicine; he also practiced in Calhoun before moving to Dalton two decades ago. He was a member of the Whitfield County Medical Society, the Medical Association of Georgia, and the American Medical Association. He is survived by his wife, Mrs. Esther Shellhorse, Dalton; two daughters, Mrs. Eben Mitchell, Toccoa, and Mrs. R. L. Callaway, West Palm Beach, Fla.; one brother, J. R. Shellhorse, Clarksdale; two sisters, Mrs. J. R. Thomas, and Mrs. W. D. Davidson, of Cartersville; three grandsons, Charles and Van Mitchell, Toccoa, and Joe Price, West Palm Beach, Fla. Funeral services were held from the home, 506 Fairview Road, Dalton, with the Rev. J. L. Clegg, Dalton, and the Rev. M. L. Keith, Calhoun, officiating. Burial was in Fain Cemetery, Calhoun.

*Dr. Hamilton Goss Ansley*, aged 43, of Decatur, died Dec. 16, 1945. He was the son of the late Dr. Wiley S. Ansley and Mrs. Roba Goss Ansley. Dr. Ansley was graduated from the University of Georgia School of Medicine, Augusta, in 1923, and interned at the University Hospital, Augusta, and St. Joseph's, Savannah. He began his practice in Decatur, which lasted 16 years, all of which time he was on the staff of Emory University Hospital, and served at one time as vice-president of the staff. He was a member, and former president, of the DeKalb County Medical Society, the Medical Association of Georgia, Southern Medical Association, the American Medical Association, and the First Presbyterian Church, Decatur. Survivors are his wife, Mrs. Dessie K. Ansley; two sons, Hamilton Goss Ansley, Jr., and Wiley Ansley III; a daughter, Jane Ansley; his mother, Mrs. Wiley S. Ansley; three brothers, Dr. R. B. Ansley, Lieutenant Commander in the Navy; Lt. Comdr. Urquhart Ansley, Charleston, and Lt. David Ansley, in the Pacific; a sister, Mrs. William S. Howland, Atlanta; two nieces, and three nephews. Funeral services were held from the First Presbyterian Church, with Dr. Hugh Bradley and Dr. Wallace Alston officiating. Burial was in the Decatur Cemetery.

*Dr. John Washington Thomason*, aged 65, of East Point, died Dec. 19, 1945. He was a physician for 32 years and a resident of East Point for 23 years. Dr. Thomason graduated from the Southern College of Medicine and Surgery, Atlanta, in 1912. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the First Baptist Church, East Point, the Elks, the Shrine, and the Masonic Lodge. Survivors are his wife; four daughters, Mrs. M. K. Puckett, Brookhaven; Mrs. E. C. Stanfield, Mrs. J. M. Blackwell and Mrs. A. G. Bell; a son, J. R. Thomason; a brother, E. V. Thomason, and a sister, Mrs. Annie Craine. Funeral services were held from the First Baptist Church, East Point, with Dr. W. A. Duncan officiating. Burial was in West View Cemetery.



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### THE CONTROL OF STATURE

J. K. FANCHER, M.D.

*Atlanta*

Only in the past decade has medical attention been directed to the control of stature. Clinicians know something about the treatment of under-height individuals, but little is known about growth prevention. This report is a summary of the etiology and results of experimental chalone, or antagonistic, therapy over a period of fifteen years in 67 patients with skeletal overgrowth. A total of 113 patients was studied in this series, but 46 were not included due to the short time of treatment or to lack of cooperation.

Cessation of growth may occur either as a result of a decrease in the amount of growth-producing hormone — either relative or absolute — or the closure of the epiphyses which is associated with sexual maturity.

A brief review of the literature reveals that a few of the endocrine preparations have been used with notable success. In 1932 I<sup>1</sup> first reported the beneficial effects of male sex gland preparations in the retarding of skeletal overgrowth in the human.

MacCullagh<sup>2</sup> asserted that testosterone propionate did not increase the rate of epiphyseal closure. On the other hand, the female sex hormone, according to Bayer,<sup>3</sup> has a decided influence on sexual maturation and epiphyseal closure. One patient treated by them developed hyperthyroidism and matured quite rapidly with an improvement in the growth rate.

Dorff,<sup>4</sup> however, contended in 1942 as a result of long observation that "androgen, a product of the interstitial cell produced

by gonadal stimulation, can be considered as favoring growth."

Finkler and others<sup>5</sup> in 1942 obtained a 62 per cent advance in growth rate in 50 children with chorionic gonadotropin.

The observations of Dorff and Finkler were based upon the treatment of sexually immature children.

Currier, Frantz and Meer<sup>6</sup> in 1941 cited the work of Drigalski and Dulthem that the male sex hormone acts as a physiologic brake on the growth hormone. Currier and his co-workers treated a patient with gigantism with this therapy with satisfactory results.

In 1940, Rubenstein and Solomon<sup>7</sup> found that large daily injections of testosterone propionate resulted in a marked growth depression in white animals, in contrast to growth stimulation from small doses of testosterone.

Again Bayer<sup>8</sup> revealed that gonadotropic hormone superimposed on thyroid treatment resulted in a sharp decline in the growth rate in one hyperpituitary giant. In another patient, male sex hormone stimulated growth before puberty.

In 1939 I<sup>9</sup> reported "Further experimental work at the Good Samaritan Clinic on the Wistar white rat has demonstrated conclusively that sufficiently high dosage of male or female sex hormone will inhibit skeletal growth in the rat. The male hormone inhibits the male more than the female rate of growth, while the female hormone seems to inhibit both sexes to a greater extent than the male hormone. A 30 to 60 per cent retardation of growth occurred over a five-month period. Every treated animal was dwarfed."

Goldzieher<sup>10</sup> in 1941 corroborated our first reports on stature retardation in humans, by reporting two patients retarded by sex gland therapy.



TABLE I\*

Case Number	Sex	Age	Starting Height In Inches	Final Height In Inches	Expected Growth	Actual Growth	Retardation In Inches	Months of Treatment	Epiphysis Closed	TREATMENT
1	F	10	65	68	7 <sup>v</sup>	3	4	28	28 mo.	AEB . . CAL . . WHOLE OVARY. CON.
2	F	10	63½	66¼	4 <sup>v</sup>	2¾	1¼	18	17 mo.	H. MATUR. FACT . . AEB . . THY . . OVARY. CONC . . CAL . . VIT. D . .
3	F	11	64	65¾	3 <sup>v</sup>	1¾	1¼	8	4 mo.	H-WHOLE OVARY SUB.
4	M	15	73½	74	2¼	½	1¾	9	9 mo.	THY . . AEDH . . GOAT'S MILK . .
5	M	14	71¼	73½	5¼	2¼	3	23	open	W-AEB . . AEDH . . CAL . . STILBEST . . ESTRO. HORM . .
6	M	15	71¼	72¼	2 <sup>l</sup>	1	1	6	open	ESTRO. HORM . . .
7	M	13	68	69¾	3 <sup>h</sup>	1¾	1¼	9	6 mo.	H-THYROID . . .
8	F	16	67½	67½	0 <sup>v</sup>	0	0	15	9 mo.	H-THEELIN . . THYROID . . GLYCERIN. OVARY. EXTR . . .
9	F	14	67¾	68¾	1½	¾	¾	19	open	STILBEST . . TESTOST . .
10	F	14	68¼	68¾	1 <sup>h</sup>	½	½	32	open	THY . . CAL . . PUE . . STILBEST.
11	F	13	67	69	3¼ <sup>l</sup>	2	1¼	45	45 mo.	AEB . . PUE . . THY . . CAL . . VIT. D . . STILBEST . .
12	F	13	64½	65½	2 <sup>h</sup>	1	1	16	open	GLYCERIN. OVARIAN EXT . . .
13	F	15	69¾	69¾	1¼ <sup>h</sup>	0	1¼	8	8 mo.	WHOLE OVARY SUB . . .
14	F	14	68¾	68¾	1 <sup>o</sup>	0	1	6	1 mo.	H-THY . . . CAL . . .
✓15	F	12	63	66¼	2 <sup>v</sup>	3¼	0	10	open	PUE . . APL . . ESTR. HORM . .
16	F	12	66	67½	4 <sup>h</sup>	1½	2½	12	9 mo.	CAL . . VIT. C . . AEB . . .
17	F	13	68¾	69¾	3¼ <sup>l</sup>	½	2¾	21	15 mo.	ESTR. HORM . . AFB . . CAL . . VIT. D1, D2 . . . .
18	F	12	65¾	67¾	5¼ <sup>h</sup>	2½	3¾	53	19 mo.	PUE . . CAL . . VIT. D2 . . .
19	F	12	64¼	66½	4¼ <sup>v</sup>	2¼	2	48	31 mo.	ESTRONE . . PUE . . AEB . . CAL . .
20	F	15	66	68¾	2½ <sup>h</sup>	2¾	0	49		PUE . . WHOLE OVARY SUB . . FOLLUTEIN . .
21	F	10	59¾	62½	3 <sup>v</sup>	2½	½	13	open	WHOLE OVARY SUB . . PITUITARY PUE . . AEB . . .
22	F	12	63¾	64¾	3 <sup>v</sup>	1	2	16	open	THY . . PUE . . WHOLE OVARY . . CAL . . WHOLE PITUITARY . . .
23	F	13	68¾	70½	2 <sup>l</sup>	1¾	¼	25	5 mo.	CAL . . AEDH . . AEB . . .
✓24	F	14	77	77½	1 <sup>o</sup>	½	½	23	22 mo.	CAL . . VIT. C . . VIT. D . .
25	F	11	59	67¼	6 <sup>h</sup>	8¼	0	28	28 mo.	W-THY . . WHOLE OVARY . . AEB . . .
26	M	15	73¼	75	3 <sup>h</sup>	1¾	1¼	34	open	STILBEST . . CAL . . AEB . .
27	M	13	70¼	72	6 <sup>h</sup>	1¾	4¼	10	10 mo.	H-STILBEST . . CAL . .
28	M	14	67¾	69½	5 <sup>h</sup>	1¾	3¼	13	open	STILBEST . . . . .
29	M	15	74½	74¾	3 <sup>h</sup>	¼	2¼	26	24 mo.	TEST. SUB . . . .
30	M	14	70	73	6 <sup>h</sup>	3	3	22	open	STILBEST . . VIT. B . . .
31	M	14	73¾	76¼	5 <sup>h</sup>	2½	2½	21	open	WHOLE OVARY SUB . .
32	M	14	71½	72¾	5 <sup>v</sup>	1¼	3¾	29	28 mo.	AEB . . .
33	M	14	70¾	74¾	6 <sup>h</sup>	4¾	1¾	24	open	ORCHIC SUB . . ORCHIC SOL . .
34	M	15	71½	72¾	2 <sup>h</sup>	¾	1¾	16	open	AEB . . VIT. D2 . . CAL . . VIT. D1
35	F	14	65½	66	1 <sup>h</sup>	½	½	39	25 mo.	AEDH . . AEB . . CAL . . VIT. D1, D2
✓36	F	10	58¾	65	8 <sup>v</sup>	8¾	0	37	37 mo.	VIT. D1, D2 . . CAL . . PUE . . AEDH . . STILBEST . . .

TABLE I\* (Continued)

Case Number	Sex	Age	Starting Height In Inches	Final Height In Inches	Expected Growth	Actual Growth	Retardation In Inches	Months of Treatment	Epiphysis Closed	TREATMENT
37	F	11	62½	67¼	7✓	4¾	2⅝	34	open	PUE . . . CAL . . . VIT. D1, D2 . . . AEB . . . AEDH . . . STILBEST . . .
38	F	12	66¼	69⅞	5+	3⅞	1⅞	41	41 mo.	AEB . . . AEDH . . . CAL . . . THY . . . PUE . . . VIT. D1, D2 . . .
39	F	15	69	69¾	1¼	¾	¼	23	3 mo.	WHOLE OVARY SUB . . .
40	F	13	65	66	3½	1	2¼	56	24 mo.	ESTRONE . . . WHOLE OVARY SUB . . .
41	F	12	69½	69½	4	0	4	6	6 mo.	H-CAL . . . WHOLE OVARY . . .
42	F	13	68¼	68¾	3	¾	2⅝	27	1 mo.	H. STILBEST . . . CAL . . .
43	F	13	69	69¼	2¼	¼	2	18	10 mo.	AEDH . . . CAL . . . THY . . . IRON . . .
44	F	15	68¼	69¼	1.2	1	0	14	1 mo.	H-WHOLE OVARY SUB . . .
45	F	13	65	66¾	2	1¾	¼	18	15 mo.	W-THEELOL . . . OVARY SUB . . .
46	F	15	67¼	67¾	1	¾	¼	6	open	PREMARIN . . . . .
47	M	11	64	73½	11✓	9½	1½	41	41 mo.	W-CAL . . . IODINE . . . AEDH . . . STILBEST . . . AEB . . .
48	M	13	68	71¾	6	3¾	2⅝	41	41 mo.	TESTICULAR SUB . . . ESTROGENIC HORMONE . . .
49	M	15	74¼	76½ 78½	2¼	2¼	0	20	14 mo.	H-TESTIC. SUB . . . THYMUS SOL . . . 8 YEARS LATER
50	M	15	70½	77⅞	4¼	7¾	0	47	open	W-ADRENAL CORTEX . . . AEB . . . X-RAY . . . OVARIAN SUB . . . CAL . . . VIT. D1, D2 . . .
51	M	18	78	78	0	0	0	10	10 mo.	W-X-RAY . . . STILBEST . . . . .
52	F	11	67	69¾	7½	2⅝	4¾	18	15 mo.	H-THY . . . AEDH . . . CAL . . . PUE . . . VIT D1, D2 . . .
53	F	10	63¼	67½	9✓	4¼	4¾	43	40 mo.	CAL . . . VIT. D . . .
54	F	8	64¼	66½	6	2¼	3¾	7	7 mo.	H-CAL . . . AEB . . . AEDH . . .
55	F	11	66¾	69¾	7✓	3	4	25	11 mo.	H-PUE . . . CAL . . . OVARIAN SUB . . . AEB . . . NO COW'S MILK AFTER 17th MONTH . . .
56	F	14	68	68	1¼	0	1	6	6 mo.	W-CAL . . .
57	F	14	66¼	66½	¼	¼	0	6	6 mo.	H-THY . . . WHOLE OVARY SUB . . . CAL . . .
58	M	14	67¾	68¾	1✓	1	0	5	open	TESTOST . . . ANDROGEN . . .
59	M	14	70	70¾	2	¾	1¾	4	open	TESTOST . . . . .
60	F	15	64¼	64¾	1½	½	½	19	1 mo.	H-THY . . . PUE . . . CAL . . . LUGOLS . . . VIT. D
61	M	16	70½	70¾	0	¼	0	13	1 mo.	H-CAL . . . VIT. D . . . AEB . . .
62	M	16	73½	74¾	0	1¾	0	6	5 mo.	W-CAL . . . VIT. D . . .
63	F	13	64¼	65½	2	1¼	¾	11	open	W-CAL . . . WHOLE OVARY SUB . . . VIT. D . . .
64	F	14	63¾	64¾	1✓	1	0	14	14 mo.	W-WHOLE OVARY SUB . . .
65	M	15	68	68¾	¾	¾	0	5	open	THYMUS . . .
66	F	13	64¾	66	2	1¼	¾	25	5 mo.	H-THY . . . PUE . . . AEDH . . . CAL . . . VIT. D1, D2 . . . . .
67	F	12	66½	67	9	½	8½	32	open	CAL . . . WHOLE OVARY SUB . . . GROWTH OCCURRED ONLY WHEN TREATMENT OMITTED FROM 19th to 29th MONTH.

Interpretation of abbreviations: AEB—alpha estrodial benzoate; AEDH—alpha estrodial benzoate orally; PUE—pregnancy urine extract; H—hand; W—wrist.

\*According to Hamblen, the epiphyses of the hand close at 15; those of the wrist, ankle, humerus and femur close at 18.

## THE EFFECT ON HEIGHT OF VARIOUS THERAPEUTIC PREPARATIONS

1. Pituitary preparations (combined)	over 16 months	0.43 inches per month
2. Maturity factor (combined)	" 7 "	0.25 " " "
3. Thymus solution (alone)	" 6 "	0.22 " " "
4. Estrogenic hormone (combined)	" 6 "	0.20 " " "
5. Testosterone propionate (alone)	" 20 "	0.15 " " "
6. Thyroid gland, dessicated (alone)	" 30 "	0.15 " " "
7. Whole ovary extract (alone)	" 108 "	0.12 " " "
8. Estrogenic hormone (alone)	" 13 "	0.12 " " "
9. Testosterone propionate (combined)	" 8 "	0.12 " " "
10. Pregnancy urine extract (combined)	" 65 "	0.12 " " "
11. Theelin (alone)	" 10 "	0.11 " " "
12. Alpha estrodial benzoate (combined)	" 143 "	0.11 " " "
13. Whole ovary extract (combined)	" 15 "	0.11 " " "
14. Pregnancy urine extract (alone)	" 42 "	0.10 " " "
15. Conjugated estrogens	" 6 "	0.10 " " "
16. Vitamins D and C (combined)	" 159 "	0.09 " " "
17. Calcium (alone)	" 37 "	0.08 " " "
18. Elix. chlorocalcium (combined)	" 19 "	0.08 " " "
19. Orchic substance and solution (combined)	" 10 "	0.07 " " "
20. Calcium (combined)	" 609 "	0.07 " " "
21. Vitamin D2 (combined)	" 131 "	0.07 " " "
22. Alpha estrodial benzoate—oral—(combined)	" 106 "	0.08 " " "
23. Whole testicular sol. (alone)	" 20 "	0.05 " " "
24. Stilbesterol (alone)	" 49 "	0.05 " " "
25. Thyroid gland (combination)	" 60 "	0.05 " " "
26. Alpha estrodial benzoate (i.m., alone)	" 38 "	0.05 " " "
27. Chorionic gonadotropin (alone)	" 13 "	0.009 " " "

CHART OF PATIENT No. 67

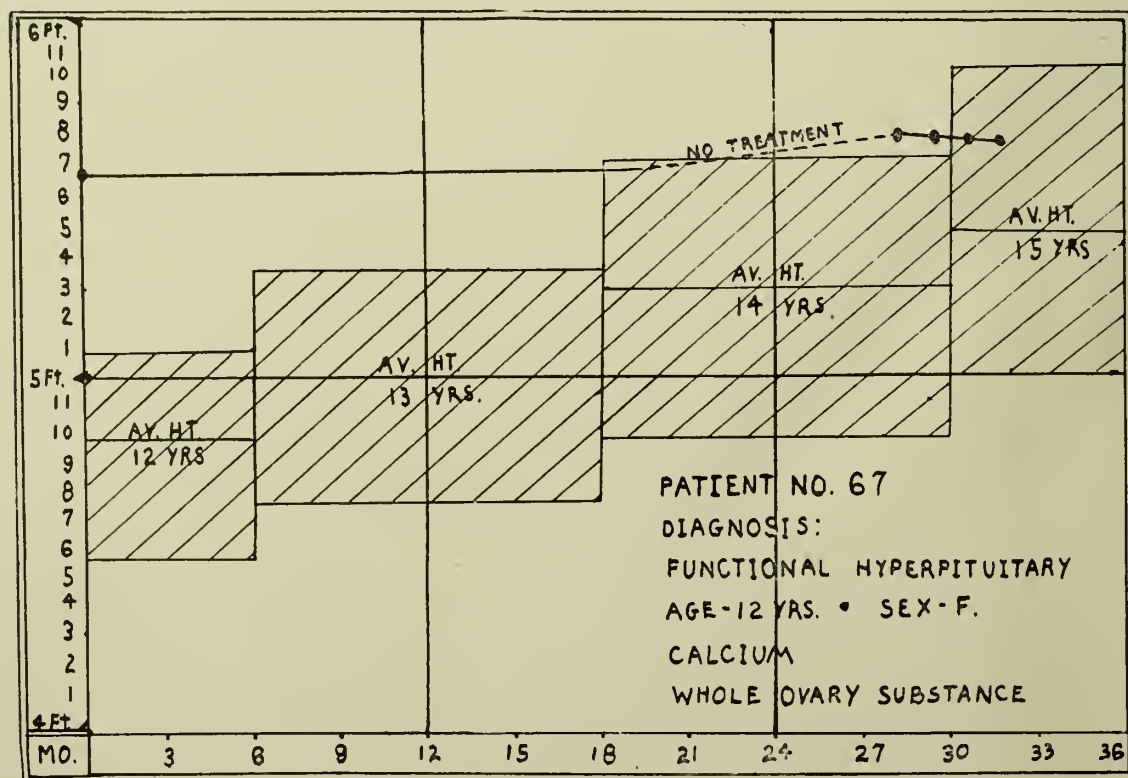






FIGURE 1

Lateral x-ray view of the skull of a pituitary dwarf demonstrating the lack of proper development of the frontal sinuses, mastoids, mandible and sella turcica.



FIGURE 4

This and figures 5 and 6 indicate the stages of epiphyseal closure in the hand and wrist during the treatment of an over-tall boy.



FIGURE 2

Lateral x-ray view of a normal skull.



FIGURE 3

Skull of a giant. Note the greatly enlarged sinuses, mastoids and sella turcica.



FIGURE 5

Note comment under figure 4.



FIGURE 6  
Note comment under figure 4.

The cases here reported were treated by me either at the Good Samaritan Clinic for Glandular Disorders or as private patients. In a number of instances the patients did not continue treatment as long as was desirable, and the results are therefore incomplete.

### Discussion

The initial height of the patients reported ranged from two inches below the highest calculated average height to eleven inches above highest normal. The average initial height for all cases was  $31\frac{1}{8}$  inches above highest normal. This would make the average over five inches above average calculated normal height for age-sex.

Puberty appeared during the eleventh and twelfth years in the majority of cases. Three patients failed to menstruate during the treatment.

- It is noticeable that in some instances it is difficult to evaluate the treatment during adolescence. Bayer<sup>12</sup> explains this as a result of the fact that the growth pattern often superseded effect of treatment.

- It was noted, incidentally, that patients



FIGURE 7  
The normal epiphyseal development of the bones of the hand and wrist.

taking one quart of raw cow's milk daily seemed to grow in spite of treatment, but they grew less when cow's milk was removed from the diet. Raw goat's milk did not seem to have this effect.

We observed that when the roentgenogram showed the epiphyses of the wrist completely closed, the epiphyses of the larger bones were bridged sufficiently to prevent noticeable further growth.

- Patients with an hereditary etiology of tallness were the most difficult to treat.

Most of the patients in our series had a high intelligence quotient and did well in school. Boys receiving testosterone were prone to be irritable and aggressive to the point of disobedience. All patients receiving stilbesterol or estrogenic factor were good natured and obedient.

One boy had enlargement of the breasts during estrogenic therapy, but this receded promptly after cessation of treatment.

It is often difficult to determine when to use antagonistic therapy for rapidly growing children. One rule is to start treatment if the actual height is already that of an



adult, or is five inches or more above the calculated *average* height for age-sex. (In this series we state the height as related to the *highest* calculated height which averages about two inches more than the *average* height). The only exception to this rule is when the psychologic condition or attitude of the patient demands that something be done. Children's playmates are often cruel, and many parents are not adequate in producing the proper mental attitudes. An inferiority complex must be treated.

•The diagnosis in all cases was hyperpituitarism, anterior lobe. There was no instance of marked genital hypoplasia.•

Of the 67 cases reported, six did not grow at all under treatment. The average growth of all cases was only  $1\frac{4}{5}$  inches, while the expected growth was  $3\frac{3}{8}$  inches per patient. The average retardation per patient for the series was  $1\frac{3}{5}$  inches. Six patients grew taller than expected under treatment with a total increase of  $6\frac{1}{8}$  inches. The total growth of all cases was  $127\frac{3}{8}$  inches. The expected growth was  $224\frac{1}{4}$  inches. The total retardation amounted to  $102\frac{5}{8}$  inches. If we subtract the  $6\frac{1}{8}$  inches gained we get a net retardation of  $96\frac{1}{2}$  inches. Fifty-two patients were retarded  $102\frac{5}{8}$  inches, or about two inches each.

### Summary

Of a series of 113 patients who were growing too fast or too tall, 67 were treated experimentally with glandular extracts for a sufficient length of time to furnish basis for this report. Fifty-two of the 67 patients, or 77.16 per cent, showed an inhibition of growth under treatment. Six of these did not grow at all. The other 15 patients either showed no decrease in the growth rate or were accelerated by the treatment.

A large number of preparations, such as testosterone propionate, stilbesterol, thyroid, calcium, vitamin D, and various extracts of ovary and testes were used over a period of fifteen years. The best results seemed to accompany the use of stilbesterol or alpha-estrodial benzoate with calcium and vitamin D. The average treatment time was nearly eighteen months per patient.

As far as possible treatment was continued until closure of the epiphyses was demonstrated by roentgenogram.

There were no serious ill effects from treatment, and in no case was there evidence of permanent sexual stimulation. Four girls had cessation of menses for varying intervals ranging from weeks to months but there was a return to normal rhythm after treatment was stopped. Nine girls were irregular.

The evidence offered seems to indicate that rapidly growing children may be safely retarded in their growth by the administration of stilbesterol or alpha estrodial benzoate with calcium and vitamin D. Based on the results of these studies, further reports should show a much greater degree of retardation of stature.

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### GENERAL SIMMONS SPEAKS ON SANITATION AND PUBLIC HEALTH

The new knowledge made available in the field of sanitation during World War II will prove invaluable in planning a national research program of health and sanitation for the coming years of peace, according to Brigadier General James Stevens Simmons, Chief of Preventive Medicine Service, Office of The Surgeon General, who spoke recently at the annual meeting of the National Sanitation Foundation, Ann Arbor, Michigan.

Tracing the Army's "long, proud tradition of research in preventive medicine," General Simmons discussed the achievements of the Army Medical Department in World War II in fields directly concerned with or contributory to sanitation. Penicillin, streptomycin, and many other life-saving drugs were a result of wartime research, while the new insect repellent, DDT, has revolutionized the control of insect-borne diseases, General Simmons pointed out. The Army's research program will not cease because of the war's end, but will continue on problems yet unsolved.

"The United States is now a leader in the field of public health," the General concluded. "Organization of research and leadership in the field of sanitation will mean increasing the strength and security of America."



## CHRONIC HYPERTHYROIDISM

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For more than twenty years I have been calling attention to a clinical entity which I have classified as "chronic hyperthyroidism", and so far as I can find there have been no references in the literature to such a condition until after 1928, and then the terms "acute" and "chronic" were not used.

In recent years an occasional paper has appeared on the subject and Hertzler in his latest book, "Diseases of the Thyroid Gland," has chapters on "acute goiter" and "chronic goiter."

I have not discarded the classification used by the American Association for the Study of Goiter, but rather have added under that classification the terms "acute" and "chronic," which are applicable in the individual case, such as "nodular goiter chronically toxic" or "nodular goiter with chronic hyperthyroidism," or "diffuse goiter with acute hyperthyroidism."

The basal metabolism reading is the yardstick which has been accepted by the profession as the standard of measurement of toxicity in goiter, and we have accepted the following rule: "If hyperthyroidism is present the basal metabolism reading is above normal, and if the basal metabolism reading is normal, then no hyperthyroidism exists." I have always contended that this rule cannot be followed blindly, as there are exceptions to all rules, and in medicine we should be careful not to use the terms *always* and *never*.

The tubercle bacillus is not always found in the sputum of a patient suffering from tuberculosis; the malarial parasite is often not found in the blood of a malarial patient; and any surgeon will tell you of patients with an acute surgical abdomen in whom leukocytosis was absent, so in goiter we have exceptional cases with clinical manifestations of hyperthyroidism with a normal or subnormal basal metabolism reading, and especially is this true in the chronic type.

This long neglected and often misunderstood phase of hyperthyroidism deserves more careful consideration at the hands of our diagnosticians and internists. These patients are too often classified as neurotics, psychoneurotic, or neurocirculatory asthenia, or cardiovascular and other functional neuroses. Undoubtedly such conditions do exist, but in many instances certain borderline cases of hyperthyroidism are erroneously classified with them, which do not respond to medical treatment, and many of them ultimately die a cardiac death.

In the diagnosis of chronic hyperthyroidism one should proceed with extreme caution for, should the surgeon do a thyroidectomy on a case of functional neurosis, the patient will not be benefited but will actually be worse than before. In suspected cases, a prolonged clinical study should be made, and if laboratory tests are not conclusive then clinical tests should be made such as the therapeutic iodine test. If ten drops of compound solution of iodine are given three times daily for fourteen to twenty-one days and the patient is clinically improved, or if there is a reduction in the basal metabolism reading, then it is fairly safe to assume that hyperthyroidism does exist and the patient will be benefited by surgery.

Much has been written about the inaccuracies of metabolism tests, which are delicate tests and often misleading. The patient may not be properly prepared or may be frightened or nervous and may not cooperate properly; the machine itself may be defective; and the technician may be inexperienced and in error. Any one or more of these will give you a basal metabolism reading which is worse than useless, and it is incorrect and therefore misleading.

A patient was referred to me recently for operation for goiter; the referring internist, who lived in a neighboring state, had made a basal metabolism reading and sent the report along with the patient. The reading showed plus 68 per cent, and when repeated in our laboratory under different conditions the reading was normal. The patient did not have a goiter, but the nerv-

ousness and throat symptoms were caused by a very different condition.

It is not generally known that many normal individuals have basal metabolism readings outside the normal range of plus ten to minus ten, and some will be between minus ten and minus twenty. If one of these individuals should show signs of a mild hyperthyroidism, with a metabolism reading of zero to plus ten, then there is a definite rise in his or her basal metabolic rate. I never subject a patient to surgery after one basal metabolism reading, and I believe it is inadvisable to accept the metabolism reading as final proof of the presence or absence of hyperthyroidism. It is a valuable adjunct in the final diagnosis, but if it is in disagreement with the clinical picture then it should be ignored.

In arriving at a diagnosis of chronic hyperthyroidism a careful history must be taken and a complete examination made and, in women, one should pay particular attention to the function of the generative organs, and search the history carefully for other causes of the nervousness, such as a drunken or philandering husband, sexual frigidity, or unequal sex life. I cured one woman of a sex neurosis by circumcising her husband. She had been married twenty years and had children who were grown, and had never had a normal sexual intercourse due to the fact that her husband completed the sexual act too quickly. She was either too timid or too ignorant to mention it, and became a nervous wreck with loss in weight, a rapid heart, insomnia and a choking sensation; and was a goiter suspect. The carefully taken history, laboratory tests and physical examination ruled out goiter and made the correct diagnosis. After circumcision of her husband "they lived happily ever afterward."

### *Diagnosis*

In borderline cases of hyperthyroidism any or several of the usual symptoms of toxic goiter may be present. Usually the thyroid gland is moderately enlarged and firm, and may be causing some pressure symptoms. The patient is nervous and may cry at times; there is palpitation and the pulse is above normal, perhaps 90 to 110;

there is a tremor and the palms may be moist and warm.

Exophthalmos is seldom present in chronic hyperthyroidism, but many patients do have slight eye signs or a definite stare, and perhaps lid-lag is present. They may have the desire and energy to do things but are without the physical endurance to perform, while the neurotic is utterly lacking in ambition and is tired all the time. They may have heat intolerance, and we should inquire as to the amount of clothing and bed clothes required in cold weather, as compared to other members of the family. The blood pressure is usually elevated slightly, but may be below normal. Occasionally there is loss in weight, but some patients have gained weight. Many of these patients have been having symptoms for several years, and some are in menopause which also may complicate the diagnosis.

Many writers have referred to these borderline hyperthyroid cases, but few have used the term "chronic" to describe this condition. Clute referred to them in 1928. Troell in 1932 reported a small series. Plumber at Mayo's in 1931 reported a case of hyperthyroidism with a basal reading of minus 9 per cent. In 1934 Gordon and Graham reported a series of cases. Link in 1934 published an excellent article on "Mild Chronic Hyperthyroidism," and Young in 1938 reported a series of cases of "chronic hyperthyroidism." In these last two articles both nodular and diffuse goiters were mentioned.

There may be an occasional patient with hyperthyroidism in whom the gland cannot be palpated but in the majority of cases there is a definite enlargement present. We often see doctors palpate the thyroid gland from the front. I prefer to have the patient seated and I stand either behind or to one side and place the tips of the fingers to either side of the trachea, just below the cricoid cartilage, and feel for the isthmus and then palpate the lobes gently against the trachea as the patient swallows. A normal thyroid gland is seldom palpable except in thin individuals.

Just why these patients with chronic hyperthyroidism should have a normal or



relatively low basal metabolism reading is not understood. Hertzler in his writings states that goiter is a continuous process and that the various classifications are just different stages along the route, and that they all terminate as cardiacs. However, he does admit that while some are very acute, others are definitely chronic in their course, and while there may be associated disturbances which may overshadow or aggravate the condition, we must not deny the patient relief by surgery from the menace of an acute toxic or a cardio-toxic state.

I have seen an occasional patient who has normally one degree of fever, and no doubt many others have normally a subnormal temperature; and so it is with metabolism; many do not measure up to the usual rule or standard. It has been suggested that certain individuals with chronic hyperthyroidism have a low threshold point as the internists say of a diabetic, and there may be a spilling over of the toxic products from time-to-time, year-after-year, with no appreciable rise in the basal metabolism reading, and it may be that the chronicity of the condition is in itself responsible for the low basal metabolism reading, in that the patient gradually establishes a tolerance to the mild thyroid toxemia without any increase in the basal metabolism reading.

In the functional neuroses the palms are usually cold, while in thyrotoxic patients they are warm. There may be weakness and fatigue, especially noticeable in the legs.

In taking the history in borderline cases, it is especially noticeable in the functional neuroses that when you ask the patient a question they never answer "yes" or "no", but usually volunteer additional information and their answers never run true to form or to the usual goiter pattern. However, we must always remember that there is no law forbidding a patient having two or more conditions at once.

I frequently find patients with a definite goiter and also some accompanying gynecologic condition which may produce additional symptoms or aggravate the goiter symptoms. The question then arises, if the patient must have two operations, which

should be done first? If the goiter is acutely toxic, by all means the goiter operation should be done first, after proper preparation, but in chronic hyperthyroidism there is little danger of postoperative thyroid crisis, so I usually do the gynecologic operation first and then eight to ten days later remove the goiter, provided the patient's condition justifies it, thereby making one hospital stay do for both operations, which is an economical item to be considered by many patients.

The great majority of my series were nodular goiters, but about one in twelve were diffuse. There were a few cases of thyroiditis in the group, including Reidel's and Hashimoto thyroids, which appear to be terminal stages of a progressive process.

In 1937 I reported a small series of 57 cases of chronic hyperthyroidism and now I have a series of 268 patients, ranging in age from seventeen to eighty-six years of age; 15 were males and 253 were females.

The basal metabolism readings were universally low in this series, ranging from minus thirty-seven to plus twenty, the majority being normal or between minus ten and plus ten. There were no deaths in the series, though there were several patients with temporary complications, such as a mild tetany, and a few with temporary loss of voice due to nerve injury.

The results in my series were uniformly good. Approximately 90 per cent reported complete relief of symptoms, while a few patients being in menopause are still nervous and report partial relief. In a few patients, perhaps where I was high-pressured into operating on doubtful cases, there was no improvement. But, generally speaking, operation was well worth while in this series of borderline hyperthyroid patients when we consider what would have happened if they had been classified as neurotics, and a large number of them perhaps would have died cardiac deaths.

### *Conclusions*

1. There is a definite group of mildly toxic goiters which are often confused with the functional neuroses.
2. These borderline cases should have adequate study before classifying them



either as chronic hyperthyroidism or as functional neuroses.

3. This policy will serve to benefit and relieve many patients with chronic hyperthyroidism, and also prevent unnecessary surgery on borderline patients who do not fall in this group.

4. Too much dependence is often placed in one basal metabolism reading, which at best is tricky and unreliable, rather than in clinical findings.

5. Neurocirculatory asthenia often simulates hyperthyroidism so closely that thyroidectomy is performed and then the symptoms are worse than before, so a careful clinical study by one familiar with these conditions should prevent this mistake.

6. The clinical iodine test will help differentiate many questionable cases.

7. Chronic hyperthyroidism is more common than is generally supposed, and the great majority of these patients are relieved by thyroidectomy.

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## PULSATING HEMATOMA

J. D. MARTIN, JR., M.D.

Atlanta

In World War II false aneurysm or pulsating hematoma was found to be one of the most frequent complications of vascular injuries. The early treatment of the injury requires judicious care if this complication is to be avoided.

The restoration of large vessel trauma is not feasible in most instances under existing circumstances. Because of the delay sometimes encountered and the massive type of injuries, the vascular damage cannot always be evaluated. Moreover, the necessity for the immediate control of hemorrhage in the presence of extensive damage to muscles, nerves, and bone frequently forbids a careful determination of vessel damage, with a planned repair of the defect. The damage to the vessel may be extensive and, if there is a large external wound, profuse hemorrhage follows. On the other hand, with a small wound of entrance by shell fragments or other missiles, massive hemorrhage in the part may result without external loss of blood. It is equally important to be observant in both of these conditions. In the first, the urgency is the control of bleeding. In the second, the repair of the damage is necessary if preservation of the limb and the prevention of late complications are to be achieved. The presence of shock and the extensive damage frequently forbid the closure of large defects in the vessel. Therefore, the recourse is ligation both proximal and distal to the site of trauma. The failure to close either or both ends may result in delayed hemorrhage, hematoma, and possibly a false aneurysm.

The anastomosis of torn vessels can occasionally be accomplished, but it should never be attempted except under ideal circumstances. The use of anticoagulants, such as heparin and dicoumarin, are extremely beneficial following vessel suture but may be definitely contraindicated. In the presence of massive soft-tissue damage,

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the possibility of secondary hemorrhage must constantly be borne in mind, and this may be the deciding factor in preventing the use of these otherwise beneficial agents.

The paramount feature in all traumatic surgery is saving the patient's life. Ligation of the bleeding vessel therefore is most essential when all other means of control are inadequate. However, the ligation of major vessels to the extremities is not without tremendous risk of losing the limb. Experience with injuries, in this and previous wars, has substantiated this belief. The ligation of popliteal or of femoral arteries is accompanied by an extremely high rate of gangrene. The longer after injury before primary ligations are performed, the greater the opportunity for recovery of the limb. Collateral circulation has thus had an opportunity of organizing. This is particularly true in cases where partial severance of a vessel has occurred and some circulation is maintained.

Every effort should be made to maintain the circulation of the limb. The leg should be immobilized to decrease the nutritional needs of the part. The reduction of the temperature of the part to 30 to 34° C. decreases the metabolic requirements and does not interfere with tissue function. The lowering of the surrounding temperature by ice bags around the leg may best accomplish this. The application of heat is contraindicated because of its effect in increasing metabolism. Following the ligation of all major vessels of an extremity, paravertebral sympathetic block should be done, repeatedly if necessary. In some instances sympathetic ganglionectomy for increasing circulation must be instituted before the viability period is lost. The greatest benefit from the latter procedures is the elimination of the reflex vasospasm that so frequently accompanies trauma to large arteries. When large arteries are ligated, the accompanying vein is usually ligated. The rate of gangrene is thought to be reduced when the vessels are ligated and severed. The basis for this is the interruption of the autonomic nerve fibers which permit the development of reflex spasm. There was insufficient clinical evidence in World War II to prove this beneficial.

False aneurysms are encountered in cases where the main vessels are not securely ligated and immediate hemorrhage is controlled by packing. The presence of infection with necrosis may produce secondary hemorrhage into the limb when an insufficient external wound is present. The blood extravasates into the part and clots at first. Later, if the mass remains present for any length of time, a true endothelial sac may be partially or completely organized. As long as blood is entering the mass, an expansile pulsation may be noted. However, when the area becomes overdilated and no further blood can enter, all pulsations cease. At that time the blood supply to the limb can be totally stopped by secondary compression of the artery as well as by an intraluminal clot. The part below the lesion will begin to swell and there will be more pain than before.

The development of such a process may occur at any time following the injury, but the period in which it is most often recognized first is from two to eight weeks. At this period the patient is being transported from the forward hospital to the rear and must constantly be observed in each installation through which he passes. The prediction of such a lesion cannot be made, but those with a history of initial profuse hemorrhage must always be viewed with great suspicion. This may be more likely to occur where large wounds are present and the primary control of bleed is accomplished by packing. Following removal of the packing and the first change of a cast, a cavity may remain which makes an ideal site into which blood may escape. Undue swelling and discomfort of the parts, following the change of a cast, should always be noted and examined. The development of false aneurysms is frequently unrecognized because most war wounds of the extremities are incorporated in plaster. Recognition of aneurysms has been made weeks later, particularly when the swelling of the part has subsided.

The diagnosis of the condition is not difficult and undoubtedly the most important single factor is to consider the possibility in each case of penetrating trauma in the



vicinity of large arteries. A mass may not be palpable, but when recent hemorrhage or impending rupture is present, the swelling may be great. With such swelling, pain is out of proportion to that previously experienced. After the sac is well developed, pulsations are seen. Pulsation is usually associated with a systolic bruit. The latter is somewhat inconstant but more frequently encountered than not. The pulsation and bruit are not usually present after internal rupture of the sac. The condition can be diagnosed in most instances before rupture has occurred, but occasionally it will not be recognized until the vessel has been exposed.

The problem is the differentiation of this condition from an abscess. This is not always easy, since all ordinary signs of pulsating hematoma may not be obvious. The only manifestations may be those of a systemic infection and of increasing swelling along the vessel. It is well, therefore, not to incise a fluctuant mass near a vessel, even if evidences of infection are present, until the probability of pulsating hematoma has been eliminated.

The treatment is somewhat divergent, depending on the stage of the lesion. In small, infected lesions an infrequent case may be cured spontaneously by occlusion of the vessel with currant jelly clot followed by fibrosis. It is well not to attempt immediate repair of these lesions unless there is evidence of impending rupture or marked pain. The longer operation can be postponed, the more likely it is that sufficient collateral circulation will be present. The optimum time is variable, but ideally from sixty to ninety days should elapse. The external wounds naturally must have been well healed and dormant infection must be excluded. Unfortunately, unless a well-organized sac develops, most wounds with extensive soft-tissue defect and even recently sutured wounds will disrupt and copious bleeding will ensue when necrosis or slough occurs. It is essential to operate early when there is a diminution of blood supply to the extremity with evidence of ischemia before the period of viability has passed. This may be shown by pallor,

absent pulsations distal to the lesion, swelling of the part, or lowering of the surface temperature.

The most important feature in operation on these lesions is to be able to control the bleeding from above. This can many times be satisfactorily done with a properly applied tourniquet, but in wounds of the upper thigh this is not always practicable. It is extremely essential that a dry field be present before operation is undertaken. Therefore, the main vessels should be exposed above the lesion in order directly to control the bleeding. A temporary tape or rubber band can be placed around the proximal artery and vein and removed later without danger. Thus the vessel can be accurately obliterated, whereas, when an approach is made through the original wound, attempt at occlusion may be accompanied by much difficulty. It is not always ideal to do a true arteriorrhaphy or an endo-aneurysmorrhaphy once the sac has been evacuated. This cannot be done when the rent in the vessel is extensive or the separation of the ends is great. If the vessel is lacerated, repair may be accomplished by the suture, but the majority of war wounds will have segmental defects in the vessel wall. A careful evacuation of the hematoma must then be made with identification of the vessel ends. When the clots are removed, the occlusion of the proximal and distal portions can be accomplished. This can be brought about by carefully placed interrupted silk sutures in the vessel ends or ligation in the ordinary manner. The temporary tapes or bands on the vessel or tourniquet above are then released in order to ascertain the presence of further bleeding. It is important not to pack the cavity tightly, because the pressure of packing interferes with the blood supply to surrounding muscles and the entire extremity. There should be adequate opportunity for drainage of blood, serum, or pus, particularly since most of these wounds are potentially infected. Primary closure of the wound is contraindicated when these cases are operated on as an emergency because of rupture or threatened rupture.



### Summary

1. The importance of recognition of pulsating hematoma is emphasized, because of the frequency of the lesion in battle casualties. Through interference with the circulation of an extremity, pulsating hematoma threatens gangrene of the part; rupture may result in fatal hemorrhage.

2. It is not always practicable to perform the ideal type of blood vessel repair in battle casualties; consequently, the frequency of ligations remains high, with constant danger of subsequent gangrene.

3. The diagnosis of pulsating hematoma can be made by the presence of swelling, pulsation, and systolic bruit over the site of an artery. All of these conditions may not be present. A pulsating hematoma is frequently infected and must be differentiated from an abscess.

4. Operation should be deferred as long as possible, provided that no interference with the blood supply is demonstrated. Delay is paramount for the purpose of promoting collateral circulation. Operation may become urgent upon occurrence of swelling, marked pain, or impending rupture. Emergency operation is by no means the most satisfactory method of handling these conditions.

5. The vascular lesions of most battle casualties are not amenable to repair of defects of the vessel walls and do require ligations of the afferent and efferent vessels into the hematoma, with or without attempt at obliteration.

6. The sac can best be obliterated early by evacuation, closure of vessels, and loose packing, allowing healing by granulation. Following obliteration of a sac either by aneurysmorrhaphy or evacuation and ligation of the vessels into the sac, the preservation of the limb should be attempted by means of increasing collateral circulation. This may be effected by sympathetic paravertebral block or ganglionectomy. The use of heat is contraindicated.

7. No attempt has been made to present the entire problem of aneurysm. The pressing question in the forward area of war is the emergency care of these conditions.

The most frequent is pulsating hematoma with rupture or impending rupture.

8. Few cases of aneurysm should be operated on early, but one should be familiar with the emergency measures for their treatment.

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### LICHEN PLANUS TREATED WITH CALCIUM LACTATE

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DUDLEY B. WARE, M.D.  
Fitzgerald

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Due to the fact this condition is rarely ever seen by the general practitioner, and no authority I have been able to find on skin diseases seems to know the cause or any definite line of treatment, is the reason I am presenting this paper.

I want to state first that I am not a dermatologist. I do not know anything about skin diseases. During my forty-six years of the practice of medicine, whenever I had a case of disease of the skin I would always send the patient to a dermatologist. I would not have spent any time with this case if it had been anyone other than myself.

*Family History:* Father died at 72. He was a very healthy man all his life until about four months before his death. Mother died at 66 of pneumonia. One sister died in infancy. Two brothers living, both in good health.

*Personal History:* Had measles and whooping cough during childhood; typhoid fever in 1902. Since that time have been in the very best of health until about August 1943, at which time I noticed a little eruption on dorsal surface of my right hand. There were only two or three small papules which had a tendency to itch at intervals. It was very slow in spreading. There was no sign of any eruption anywhere else until about two weeks afterwards I noticed it beginning on dorsal surface of my left hand. It gradually began to spread on both hands, itching at intervals. After about sixty days these papules took on a peculiar glistening appearance, with a peculiar grayish linear striation. At times the lesions appeared as if covered by a scale. At first these papules were multiple, angular, polygonal or faceted in shape and of a reddish color, at times changing into a dull bluish-red or purple color. The eruption spread very slowly on the back of both hands and finally began to appear on my wrists. After about two months from the time I noticed the eruption on my hands, I began to have a slight itching on my neck just posterior to the lobes of ears, just enough itching that a person would think a fly had lit on his neck and one rub with the hand would relieve it. That gradually got worse and the skin began to assume a reddish color extending from side of neck with a distinct line of demarcation which kept spreading forward on both sides of my face until two-thirds of my face was involved with this distinct line of demarcation gradually extending forward, and the tip end of my nose turning very red, a spot about the size of a dime. About thirty days after I noticed this eruption on

my hands I went to a dermatologist. After examination he told me it looked very much like lichen planus. I asked him what the cause was; he said he did not know. I then asked what was the prognosis; he said it was not very good, some got well and a lot of the cases did not get well. I then asked what the treatment was; he said about all the treatment was to take intramuscular injections of bichloride of mercury once a week, and intramuscular injections of bismuth once a week, and keep out of the sun. He suggested giving both hands x-ray treatment, which he did. The x-ray treatment seemed to make it very much worse; the itching became much worse after a few days of the x-ray treatment. I used calamine lotion two or three times a day as a local application, which seemed to help the itching at times. The trouble continued to get worse and spread. After two weeks I decided I would go to another dermatologist. So I went to Jacksonville, Florida, and consulted one. After examination he pronounced it lichen planus. I asked him the cause; he told me the same as the other one, and also advised intramuscular injections of mercury and bismuth. His prognosis was about the same as the first one. So I went back home with no encouragement.

I did not like the idea of taking intramuscular injections unless I knew it was going to be of some benefit, therefore I had not taken any treatment except soothing lotions.

I waited about two weeks longer and decided I would go to Augusta, and was checked by one whom I consider to be one of the best internal medical men in the state. He pronounced me, with the exception of this eruption, to be in perfect health. He took me to a dermatologist and after his examination he was of the opinion that it was not lichen planus, but thought probably I was allergic to something. He asked me about my work in the operating room; I told him I operated nearly every day. He said it might be that I was allergic to rubber gloves, and advised staying out of the operating room for awhile and see if that had any effect on the trouble. I did not think that was the cause, as I had been using rubber gloves in the operating room for the past thirty years, so I refused that treatment.

I went home and continued my work and watched the condition of my hands and face gradually get worse. I later decided I would go to the Mayo Clinic. About Nov. 1, 1943, I went there and was examined by a dermatologist and he stated that it was a case of lichen planus. His prognosis and treatment were the same as the other two that made the same diagnosis. On my return home I stopped in Atlanta and called on a doctor friend of mine whom I consider one of the best on internal medicine. I told him I had been to several skin specialists and what their diagnosis was and I was not satisfied with any treatment that had been prescribed, so I was coming to him for treatment. He advised taking heavy doses of vitamins A and D, 25,000 to 30,000 units three times a day. That sounded better than taking muscular injections, so I came home and took that for about two months, but without any improvement. After giving the heavy doses of vitamins a trial and seeing no improvement I then decided I would go to Johns Hopkins Hospital.

About May 1, 1944, I went to Johns Hopkins. I was referred to a dermatologist. After his examination he said he thought it was lupus erythematosus rather than lichen planus. His prognosis was not good. He advised the same treatment as the other dermatologists, namely mercury and bismuth injections, so I had about come to the conclusion that I had about worked all the medical centers and I would come home and make the best of it. During all this time my general health was good.

While in Baltimore I called on a good friend of mine, Dr. Curtis F. Burnham, who operates the Howard A. Kelly Clinic and who had been an associate of Dr. Howard Kelly for many years before his death. I told him why I was in Baltimore, and showed him the eruption on my hands and face. After looking at it he told me he would tell me of a case of lichen planus that came to see him about four months previous. This patient had been treated for sometime by a good dermatologist without any results, so he decided he would have a test made of her blood for calcium. Upon this examination he found her with a calcium deficiency, so he gave her large daily doses of calcium lactate with vitamins A and D; he gave her about 80 grains a day of calcium lactate. After one week's treatment, he stated, there was a marked improvement; after thirty days' treatment she seemed to be entirely well. He stated it had been about four months since he began treatment and she showed no sign of the trouble returning. He was anxious for me to try the treatment as that was the only patient he had treated with calcium lactate. He took me up to his laboratory and had the laboratory technician make a calcium test of my blood, and found it low in calcium; it was down to seven milligrams per hundred cubic centimeters of serum. Normal for adults is from nine to ten milligrams, children ten to twelve. He advised me to take large doses of calcium lactate and also large doses of vitamin A and D. I told him I had taken from 75 to 100 thousand units of vitamin A and D daily for about two months and I thought I would try out the calcium lactate alone and see what the results would be.

I came home and began taking 80 to 90 grains a day of calcium lactate, and no other medicine. In one week I could tell there was a marked improvement. After continuing the treatment for thirty days the eruption had entirely disappeared; the redness had faded until you could just detect the line of demarcation. In a couple of weeks more the trouble had all disappeared, leaving large white spots on the skin due to the loss of pigment. The pigment began to gradually return until now it is hardly noticeable.

Will state, after taking calcium lactate for six weeks, I had a blood test made; it showed the calcium had gotten up to normal, eleven milligrams per one hundred cubic centimeters of serum.

As I stated in the beginning of this paper, I do not know anything about skin diseases and whether or not this was a case of lichen planus, I do not know; but do know I had a calcium deficiency and it was brought up to normal with calcium lactate, and the eruption disappeared and has not returned.



# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

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FEBRUARY, 1946

## TWO NUTRITIONAL AGENTS FOUND EFFECTIVE FOR DISEASED LIVER

Two nutritional agents have been found to reverse the degenerative process which leads to death in cirrhosis of the liver, according to A. J. Beams, M.D., of Cleveland, writing in the January 26 issue of *The Journal of the American Medical Association*.

Dr. Beams, who is from the Department of Medicine, Western Reserve University School of Medicine, treated 20 patients suffering from this disease.

Besides being given a high protein, low fat diet supplemented by yeast, the treatment consisted of a combination of the nutritional agents, choline and cystine.

Choline prevents the deposit of fat in the liver. Cystine is the chief source of sulfur in food which is a necessary constituent of a complete diet.

The principal contributing cause of cirrhosis of the liver is alcoholism, but it may result from chronic poisoning with metals or from infectious diseases, especially syphilis. Dr. Beams states that in his group of patients the incidence of alcoholism was about 85 per cent.

Dr. Beams' study reveals that only patients with large livers were benefited by supplementing choline and cystine with the special diet. Twelve of the 20 patients with livers which were not enlarged did not respond to the treatment, whereas seven of the eight patients with large livers made a good recovery.

Citing the history of one patient whose life was saved by this treatment, the author says: "This case represents an instance in which choline and cystine appeared to supply the factors necessary to reverse the process in the liver. They could not be supplied by diet alone because the patient was not able to tolerate large amounts of food. In instances of this kind the choline and cystine are comparable to vitamin concentrates, which are often necessary in addition to diet in the treatment of certain deficiency diseases."

The author concludes with this cautionary statement: "It is important to emphasize the limitations of the treatment of cirrhosis. Up to the present time there has been no treatment which has been found that alters fibrosis of the liver. Recovery of liver function therefore must depend on the arrest or reversibility of the other pathologic changes which are found in cirrhosis."

## FERTILITY AND EDUCATIONAL LEVEL OF PARENTS

It has been commonly observed that the reproductive rate in American families tends to decrease with advance in the educational attainment of either the husband or wife, said the *Statistical Bulletin* of the Metropolitan Life Insurance Company for November 1945. To this well-established fact may now be added a further observation; namely, that this decrease is influenced to a greater degree by the education of the wife than by the education of the husband. The pertinent data derived from the last census are set forth in the table here produced.

"The data in the upper tier of the table show, for the country as a whole, the inverse relation between fertility and educational attainment. For example, in families where neither the husband nor the wife continued their schooling beyond the seventh or eighth year, there were 544 children under 5 years per 1,000 wives. In families where the wife had only a grade school education but the husband had one or more years at college, the corresponding rate was only 431 children under 5 years per 1,000 wives, or 21 per cent less than the former figure. In the contrary situation, where the husband had only seven or eight years of grade school and the wife had college training, there were 357 children under 5 years per 1,000 wives; in this case the adverse effect upon the reproductive rate amounted to no less than 34 per cent, as compared with families in which both parents had but limited schooling. Further study of the columns of the table reveals the fact that the rates among college women tend to vary less according to the schooling of their husbands than do the rates of women of lower educational status.

"The general character of the relation between fertility and educational attainment in the country as a whole is observed in both urban and rural areas, as may be seen from an inspection of the various tiers of the table. To take an example for rural farm families: where both parents had only a grade school education, the number of children under 5 per 1,000 wives was 649; where the wife had only seven or eight years of schooling and the husband had one or more years of college training, the corresponding number of children was 556; and where the situation was reversed, the figure was 453.

"As one would expect, for each category of educational attainment, the rates are highest for families living in rural farm areas, next highest for residents of rural non-farm communities, and lowest for urban families. As a matter of fact, the variation of the rates as observed in the table is influenced more by the area of residence than by the education of the parents; as regards the latter, the variation with the educational attainment of the wife is significantly greater than that with the education of the husband."



CHILDREN UNDER 5 YEARS OLD PER 1,000 WIVES\* ACCORDING TO  
EDUCATIONAL ATTAINMENT OF HUSBAND AND WIFE;  
UNITED STATES, 1940, URBAN AND RURAL

MAXIMUM YEARS OF SCHOOL COMPLETED BY HUSBAND	MAXIMUM YEARS OF SCHOOL COMPLETED BY WIFE					
	Grade School			High School		College
	Under 5†	5-6	7-8	1-3	4	1 or more
TOTAL UNITED STATES						
Grade school: Under 5†..	720	735	641	535	379	278
5-6.....	740	645	613	573	478	383
7-8.....	628	614	544	503	438	357
High school: 1-3.....	564	548	499	459	386	389
4.....	428	495	459	421	344	336
College: 1 or more.....	448	599	431	387	350	309
URBAN						
Grade school: under 5†..	586	592	508	464	297	189
5-6.....	553	535	508	507	407	296
7-8.....	535	521	468	445	382	279
High school: 1-3.....	435	462	446	416	344	377
4.....	366	424	417	384	318	307
College: 1 or more.....	370	424	376	352	329	292
RURAL NON-FARM						
Grade school: under 5†..	724	727	682	556	456	384
5-6.....	721	662	635	600	499	383
7-8.....	675	636	577	538	466	358
High school: 1-3.....	697	603	529	502	432	378
4.....	504	578	496	469	369	349
College: 1 or more.....	400	509	553	423	394	336
RURAL FARM						
Grade school: under 5†..	820	832	737	634	513	568
5-6.....	884	737	715	649	589	485
7-8.....	713	722	649	604	529	453
High school: 1-3.....	612	637	627	566	483	405
4.....	657	626	574	544	467	461
College: 1 or more.....	503	1,099	556	550	472	428

\*Native white women of ages 15 to 49 married once and living with husband. The rates were standardized for age on the basis of the age distribution of the total female population at ages 15 to 49 in the United States, 1940. Source for basic rates: U. S. Bureau of the Census, *Population, Differential Fertility, 1940 and 1910—Women by Number of Children Under 5 Years Old*, Washington, D. C., 1945, Table 30.

†Includes cases where schooling was not reported.

## FATAL ACCIDENTS IN 1945

The death toll from accidents of all types in the United States in 1945 is estimated, on the basis of incomplete data, to be around 96,000, or 1,000 more than the number that occurred in 1944, according to figures compiled by the Metropolitan Life Insurance Society. The increase was due solely to a rising tide of motor vehicle fatalities that set in just after V-J day, when restrictions on the use of gasoline were removed. The motor vehicle toll in 1945, it appears, will be in the neighborhood of 29,000 lives, some 5,000 in excess of the number in 1944. This increase in motor vehicle fatalities was more than enough to offset substantial declines in the numbers of deaths due to occupational accidents, accidents among men in the armed services, and accidents of a catastrophic nature.

"Deaths from accidents in and about the home probably will run a few hundred above the total of 32,000 recorded in 1944. Home accidents, once again, were the leading class of fatal accidents.

"Now that the war is over, it is of interest to observe in retrospect that the number of deaths from accidents in the war years ranged from a low of 95,000 in 1944 to a high of 99,000 in 1943. Thus, the figure of 101,500 deaths recorded in the year 1941 was not reached during the war period, although past experience had led us to believe that an even larger toll might have been expected. And this anticipated increase would undoubtedly have occurred had it not been for the fact that the enforced reduction in motor vehicle driving brought the toll from this cause down from approximately 40,000 deaths in 1941 to around 24,000 in both 1943 and 1944. Unless the safety program as it relates to motor vehicles is intensified, and unless radical changes take place in our driving habits, it is almost certain that the deplorably high figures for the prewar years will soon be back again.

"Occupational fatalities, it is encouraging to report, were kept at prewar levels throughout the war period, despite the unusually high level of employment that prevailed during those years and the large number of inexperienced workers who were employed. The effective cooperation of management and labor in the all-out safety campaign proclaimed by the President in the summer of 1941, undoubtedly did much to keep down the mortality in this trying period.

"Catastrophes — those accidents in which five or more persons are killed — were less frequent and took considerably fewer lives in 1945 than in the preceding year. Up to the closing days of 1945 our records show a total of around 1,700 deaths in such accidents, or less than half the corresponding number for 1944. Nevertheless, the toll in 1945, as in the other war years, was above that for the years immediately preceding

our entry into the conflict. There were fewer victims of catastrophes in 1945 than in 1944 in tornadoes; in fires; in service flying crashes; in accidents resulting from the manufacture, storage, and transportation of explosives; as well as in water transportation, mining, and railroad accidents. More deaths, however, were recorded both in bus and commercial air transportation.

"There was only one accident in 1945 in which more than 50 persons were killed, whereas in 1944 there were eight such accidents. The greatest loss of life — 119 persons — in any one catastrophe in 1945 was in the tornado that swept through parts of Oklahoma, Missouri, and Arkansas during April. Tornadoes in Alabama and Mississippi killed a total of 13. Last August, 34 persons died in a collision of two railroad trains in North Dakota."

## AMINO ACIDS EFFECTIVE IN ULCER RELIEF

A new treatment for stomach ulcers which gives relief from pain within 48 hours and eliminates all x-ray evidence of the disorder within three weeks has been developed by Dr. Co Tui of New York University College of Medicine under the sponsorship of the Office of Scientific Research.

The method involves frequent feedings of pre-digested proteins in the form of amino acids. These can be injected into the blood or administered orally. They are especially valuable in the pre-surgical improvement of ulcer patients, who are usually unable to eat or retain food, and also in rapid postoperative restoration.

Four pre-surgical patients in an initial test were treated by Dr. Tui by feedings of amigen, a mixture of all essential amino acids, extracted from milk and hog pancreas. Patients received two-hourly feedings of a food made with this extremely rich protein. Pains ceased within 24 hours, and blood disappeared from stools in 26 hours. Weight gain was rapid. Complete healing was found in one case; in another, the patient went home, refusing surgery; and in the remaining two, healing was rapid after surgery. The same success was met in a subsequent group of 27 patients. X-ray examination showed that ulcer openings were filling with healthy tissue as a result of the treatment.

Similar results are reported in Gastroenterology by Dr. J. S. Levy.

The Medical Association of Georgia will hold its next annual meeting at the City Auditorium, Macon, May 7-10, 1946.

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

## WOMAN'S AUXILIARY : OFFICERS 1944-45

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### AUXILIARY NEWS

At a recent meeting of the Bibb County Medical Auxiliary, B. F. Merritt, Jr., recently returned to civilian life after serving several years in the African and European theaters as a lieutenant colonel in the army, talked on "Compulsory Military Training." The meeting was held at the home of Mrs. Charles McLaughlin on Ingleside Avenue with Mrs. Sam Patton as hostess with Mrs. McLaughlin.

Mr. Merritt, addressing a large audience of doctors' wives, many of them new members of the auxiliary or members recently returned to the group since their husbands have returned from the armed forces, gave two reasons why the United States should have compulsory training. He said that in the event of other wars to come there would not be time to train men, and that the country must win the peace and must have a standing army to keep it. He pointed out that "civilization cannot stand another war," giving illustrations of depleted resources he had seen in Europe and saying that no facilities were left there for a basic livelihood. He added that the United States is the only country with resources left to fight another war and survive it, and pointed out the terrific cost in lives and material.

Mr. Merritt also pointed out that, with compulsory training, a man is already classified in the reserves and ready to be drawn into the place best suited to him in the event of war. He also said that having had some training, a man would not feel such drastic change in his mental attitude when he was called for service as many men felt in the recent war.

The program was followed by tea, served from a table centered with white chrysanthemums with more flowers encircling the white candles at each end.

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The Auxiliary to the Fulton County Medical Society had a rare treat at their meeting February 1, when Dr. Paul Beeson, Associate Professor of Medicine at Emory University spoke. Dr. Beeson was born in Alaska, educated in Canada, graduating from McGill University in 1933, and is an outstanding authority on penicillin. He

was in England at the beginning of the war and his work here is chiefly investigative.

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The Auxiliary of Fulton County Medical Society will present Mrs. Donald Hastings, well known authority and lecturer on flower arranging, in a series of four lectures beginning the first Monday in February and continuing for each Monday during the month.

Mrs. Hastings' first lecture, February 4, will be on "The Technique of Flower Arrangement"; and second on "Flower Arrangements in the Home"; third, "Flower Arrangements for Special Occasions," such as Christmas, church, etc., and her last, "Constructive Analysis of Arrangements Submitted by Members of the Class."

The lectures will take place at the Academy of Medicine.

### PUBLIC RELATIONS COUNSEL FOR HOSPITALS

Terminating two years as director of the Department of Public Relations and secretary to the Council on Public Relations of the American Hospital Association, Jon M. Jonkel has announced his resignation effective January 5 to establish an organization specializing in the public relations problems confronting hospitals.

A broad public education program is extremely important at the national level, according to Mr. Jonkel, but individual hospitals too must engage in continuous programs that will improve and maintain the quality of public opinion about hospitals. The contemplated public relations program of the Association will call attention to hospitals' contributions to the national welfare but each hospital must adjust its public relationships and should explain itself to the public that supports it if continued support is expected.

Mr. Jonkel will offer assistance in the public relations programs of individual hospitals and will serve as a public relations consultant in fund raising campaigns. His services will include public opinion surveys, an audit of the hospital's work that has a bearing upon public opinion, preparation of year-long public education and employee programs, and the development of the materials that will implement any recommended program. His offices will be located in Chicago.

The Medical Association of Georgia will hold its next annual meeting at the City Auditorium, Macon, May 7-10, 1946.



## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1003 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, WALnut 8911; residence, JACKson 7979.

### GEORGIA NURSE ANESTHETISTS

MRS. RUBY L. RIDLEY, R.N., *President*  
*The Southeastern Association of Nurse Anesthetists*

The American Association of Nurse Anesthetists held its organization meeting in Cleveland, Ohio, June 1931. This meeting, attended by 49 anesthetists, representing twelve states, was called by the late Miss Agatha Hodgins, then director of anesthesiology at the University Hospitals of Cleveland, Ohio.

The object of forming this organization was to advance the science and art of anesthesiology. Officers were elected. October of the same year, by-laws and a constitution were adopted. Nearly two years were spent trying to find a place where meetings could be held to the best advantage. On May 10, 1933, a letter came from Dr. Bert Caldwell, inviting the nurse anesthetists to meet with the American Hospital Association. The first annual convention was held in conjunction with the Hospital Association, September, 1933, at Milwaukee, Wisconsin. With this annual meeting, membership grew rapidly.

Quarterly bulletins were inaugurated at the 1934 meeting, and in October 1937 a full time secretary was appointed and headquarters were moved from Cleveland, Ohio, to Chicago, Illinois. The Georgia organization was formed in 1936, and in 1939 became a part of the Southeastern Assembly of Nurse Anesthetists, holding annual meetings with the Southeastern Hospital Association.

Membership in this association is by written examination, held semi-annually in all sections of the United States. Requirements:

1. Graduation from an accredited high school.
2. Graduation from a school of anesthesiology, giving an organized course of not less than six months.
3. If prior to 1939, administration of anesthetics for six years continuously in an institution approved by the American College of Surgeons.

#### 4. Annual membership dues.

The aim of the Georgia Association is to enhance the education of the membership by attending and participating in annual meetings of the American and local association, also by attending institutes conducted by the American association.

Atlanta nurse anesthetists meet once each month for discussion of new agents and materials in order to understand the advantages and to help solve the problems of each other.

The Georgia State Nurses' Association has given space to the anesthetists in order that a book shelf can be maintained in the State Nursing Headquarters Library, 131 Forrest Avenue, N. E., Atlanta. Books and magazines on anesthesia will be available to all Georgia nurses and the general public.

We look ahead to the time when all hospitals using nurse anesthetists will have a full staff of accredited anesthetists who have had training in all agents and methods. The Institute for Instructors in Anesthesiology held last October, in Chicago, was attended by 140 anesthetists from 34 states and Hawaii. Of this number six were from Georgia.

With increasingly higher standards for entrance to nursing schools, the field of anesthesiology for nurses will continue to grow.

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#### SPECIAL ANNOUNCEMENT

Miss Phoebe M. Kandel, R. N., chairman of the Temporary Committee for Orthopedic Nursing Consultants, National League of Nursing Education, for series of institutes in February, for the Georgia League of Nursing Education, announces plans for a month's visit to Georgia by Miss Lois Olmsted, orthopedic consultant.

Miss Olmsted will hold institutes beginning February 4, in Savannah, Augusta, Athens, Milledgeville, Macon, Columbus, Warm Springs Foundation, Newnan, Atlanta, Rome, Gainesville, and possibly other cities.

(Continued on page 48)

**GEORGIA DEPARTMENT OF PUBLIC HEALTH**T. F. ABERCROMBIE, M.D., *Director***DDT FOR MALARIA**

Malaria in Georgia, as in other parts of the United States, has become a disease of decreasing importance, when viewed in numbers of deaths. The total number of deaths from malaria in the entire United States in 1943 was less than the number of deaths from malaria in Georgia during 1936.

It is not to be assumed that this decline will continue in such a marked manner unless there should be some stimulus which would result in lowering the transmission rate to a point where the disease would not perpetuate itself.

The rapid demobilization of the forces and their return to civilian life, particularly those who have seen service in the malarious areas of the South Pacific, will perhaps have a very marked influence on the upward trend of malaria during the next few years.

There may even be a return of the seeming cyclic trend of the disease which manifested itself during the past two decades.

To encourage the downward trend of the disease and to counteract the effect of returning carriers, there was inaugurated in 1945 a program of systematic spraying of houses with an emulsion containing the new "miracle" Dichlorodiphenyltrichloroethane, commonly known as DDT. The material was applied with a flat spray to the walls, ceilings and porches of homes in the areas selected. After evaporation of the emulsion, there remained an even DDT crystals residue which retained its toxic effect on insects, alighting on or crawling over the surface for a period of three months.

A very careful survey by a trained entomologist during the latter part of the season resulted in finding only two live mosquitoes in houses which had been sprayed with DDT. One of these mosquitoes died shortly after being found and the other had apparently not been in contact with the walls or ceiling as she was found on the clothes in a closet. The survey only included houses in the proximity of known mosquito breeding areas where numerous specimens were available in unsprayed outhouses.

The DDT residual spray is effective against a wide variety of insects, including most of the household pests: flies, mosquitoes, ants, bed bugs, fleas, moths, and certain varieties of roaches. A very prominent physician in one southwest Georgia community considered the program very desirable considering its effect on flies alone. Prior to the spraying program,

patients in unscreened "shotgun" houses were often covered with flies. The examination and treatment of patients in such surroundings must be experienced to be understood. Though unscreened houses sprayed with DDT very seldom had any living flies in them.

DDT presents no hazard to the general public in the operations as planned and conducted in Georgia. Crew personnel are trained and supervised in proper technics so as to eliminate possibility of injury to themselves.

All or a part of fourteen counties in the more malarious sections of Georgia were selected for the residual spray program during 1945. A great deal of valuable experience was acquired, and technics were developed for economical application of the spray. The efficiency of the Georgia program is demonstrated by the fact that the labor cost of spray application was only 43 per cent of the average of that in other states.

The program in 1945 was limited by the amount of DDT available for civilian use. DDT is now plentiful; a broad program has been planned for Georgia. Exclusive of cities over 4000 in population, 54 counties from which have been reported the highest number of deaths from malaria for the period 1938-42, have been offered the program in 1946. Alphabetically, these are listed as follows: Bacon, Baker, Ben Hill, Bleckley, Brantley, Brooks, Bryan, Bulloch, Burke, Calhoun, Camden, Clay, Colquitt, Crawford, Crisp, Decatur, Dodge, Dooly, Dougherty, Early, Echols, Emanuel, Grady, Houston, Irwin, Jeff Davis, Jefferson, Jenkins, Johnson, Laurens, Lee, Liberty, Long, Lowndes, Macon, McIntosh, Mitchell, Montgomery, Pulaski, Randolph, Screven, Seminole, Sumter, Telfair, Terrell, Tift, Toombs, Treutlen, Turner, Washington, Wayne, Webster, Wilcox, Worth.

The population to be protected is 713,300, the houses to be sprayed twice during the season, March 1 to September 30. The program is initiated and operated through the local boards of health.

Approximately 30 per cent of the cost of this program is to be borne by the local government for spray crew personnel and spray crew transportation. The local outlay will not average over 50 cents per person the season.

Each house requires an average of four gallons of 5 per cent DDT spray. Considering that an average family consists of four persons, the labor cost of application mentioned above is approximately one-twelfth the cost of the commercial insecticide. Were the spray materials for this program purchased by individuals or



communities, the cost for this item alone for the 54 counties would be over \$4,000,000.

Liberal allocations by the U. S. Public Health Service, through the State Health Department, volume purchases of equipment and materials, and efficiency in spraying technics, have made the greatly expanded program possible. DDT and related chemicals are purchased in carload lots. More than a half-million pounds of DDT will be used in Georgia in 1946.

Actual spraying of homes requires a knowledge of the location of every house to be sprayed. Each home must be visited prior to the date of spraying to acquaint the householder with preparation of the house. All of the walls must be cleared and furniture moved to the center of the room where it may be covered with tarpaulins. This operation must be done by the householder, who is advised to remain outside of the sprayed rooms for 30 minutes during evaporation and dissipation of the solvent used in the spray.

As there are no maps available showing all houses and roads in the counties, it is necessary to make new maps of every county and thickly settled community embraced in the program. The houses are numbered in the field to correspond with map designations. While interviewing householders and preparing spray crew routings, information is also secured on fundamental sanitation data at each house location.

The maps, house numbers, and sanitation data will all prove invaluable, over and above the spraying program, for future health department activities. The maps should also be useful in road planning and maintenance, school bus routings, REA planning and many other local activities.

It is not anticipated that every case of malaria in 1946 will occur in one of the 54 counties proposed for operation. The overall coverage however will include all of the endemic malaria portion of the State and it will be possible to establish spray crews for spraying the homes of all positive malaria carriers in adjoining counties. The only requisite for this operation will be a report of a blood film verified case or carrier of malaria from the home to be sprayed.

While spraying is done only in the nightly inhabited buildings, entire communities have reported an almost complete elimination of flies due to spraying. Tremendous reductions in numbers of all household insects have been reported universally, and a reduction in insect borne diseases of all kinds may be expected. In addition, it is probable that there are other diseases transmitted by insects which may show a corresponding decrease in incidence.

Thus, it is believed that this systematic spraying of houses with DDT will provide the necessary safeguard against the returning malaria

carrier, will provide the stimulus required to send malaria incidence still lower, will significantly reduce all known insect borne diseases and others the transmission of which is not clear, will provide comfort and contentment for thousands of people who are now bedeviled with household insects, and will furnish a means of contact through which it will be possible to render public health service to every home in the area covered.

LOUVA G. LENERT

*Associate Engineer, Malaria Control*

## GEORGIA NURSES

(Continued from page 46)

Topics for the institutes will be *Posture in Nursing* (with slides). Lectures will be aimed at discussing new ways to interest the student in improving her body mechanics, both because of the personal satisfaction it will give her and as a protective device for herself and the patient. Also orthopedic principles in general nursing, emphasizing ways of preventing common deformities in patients who are bedfast for long periods, such as the patient with hemiplegia, cardiac disease, the patient in Fowler's position, etc. Many other topics of paramount interest and concern will be studied.

## NEWS ITEMS

The Fulton County Medical Society held its Forty-first Anniversary Meeting and Banquet at the Biltmore Hotel, Atlanta, January 4. The program was: Call to order by the President; Installation of Officers; Announcement of Committees; Inaugural Address by the President; Miscellaneous business and entertainment. Officers for 1946: President, Dr. T. P. Goodwyn; President-Elect, Dr. R. Hugh Wood; Vice-President, Dr. Calvin B. Stewart; Secretary-Treasurer, Dr. McClaren Johnson; Board of Trustees: Dr. Don F. Cathcart, chairman, Dr. A. O. Linch, Dr. R. Hugh Wood, Dr. Calvin B. Stewart, Dr. Wm. Perrin Nicolson, Dr. Hartwell Boyd, Dr. Joseph C. Massee, Dr. T. P. Goodwyn, Dr. McClaren Johnson. Judicial Council: Dr. Chas. H. Daniel, chairman, Dr. Alton V. Hallum, J. Elliott Scarborough. Delegates: Dr. L. Minor Blackford, Dr. A. O. Linch, Dr. Lester A. Brown, Dr. Joseph C. Massee, Dr. C. W. Strickler, Jr., Dr. Hugh Hailey, Dr. Mark S. Dougherty, Dr. W. A. Selman. Alternate Delegates: Dr. Don F. Cathcart, Dr. Walter W. Daniel, Dr. Wm. C. Warren, Jr., Dr. Alton V. Hallum, Dr. Murdock Euen, Dr. Olin S. Cofer, Dr. George W. Fuller, Dr. Wm. B. Armstrong, and Dr. George A. Williams.

Dr. Emmett S. Brannon, Rome, former instructor in the Emory University School of Medicine, and on the visiting staff of Grady Hospital, Atlanta, has joined the staff of McCall Hospital, Rome, where he will practice internal medicine.



Dr. Linton S. Boyette, Ellaville's only doctor, who has maintained a steady pace of 16 or more hours a day to provide medical attention for families in a 15-mile radius during the war, has been chosen Schley County's man of the year.

Dr. Donald L. Butterfield, Waynesboro, recently discharged from the U. S. Army, after more than five years' service, announces the opening of his office at 217 East Sixth Street, Waynesboro, for the practice of medicine and surgery.

Dr. Abe J. Davis, Augusta, Richmond County Health Commissioner, recently attended a meeting of the State Board of Health and its advisory council in Atlanta. He is a member of the advisory group.

The Richmond County Medical Society meeting was held at the University Hospital, Augusta, December 27. Dr. Hervey M. Cleckley read a paper entitled, "Everyday Psychiatry." Officers for 1946: Dr. Perry P. Volpito, president; Dr. Goodrich Henry, president-elect; Dr. David R. Thomas, vice-president; Dr. H. P. Harrell, secretary-treasurer. Four members elected to the Professional Services Committee are: Dr. Victor Roule, Dr. Robert McGahee, Dr. Ralph Chaney and Dr. W. G. Cranston. Other members, appointed by the dean of the University of Georgia School of Medicine, Dr. G. Lombard Kelly, are: Dr. V. P. Sydenstricker, Dr. John Sherman, Dr. Phillip Mulherin and Dr. Richard Torpin.

Dr. Carter Davis, Atlanta, recently returned from the Pacific Theater of Operations.

Dr. Mark S. Dougherty, Atlanta, who has been in the Philippines for the past year, announces the re-opening of his offices at 139 Forrest Avenue, N. E., Atlanta.

Dr. C. Dixon Fowler, Atlanta, announces his release from military service and return to the practice of medicine, 905 Medical Arts Building, Atlanta. Practice limited to the diseases of infants and children.

Dr. Luke Garrett, Jr., Austell, recently discharged from the U. S. Army after nearly four years of service, has re-opened his office at Austell for the practice of medicine.

Dr. E. Leonard Graydon, Atlanta, who has been with the United States Public Health Service assigned to the Navy since 1942, has been placed on the reserve roll with the rank of commander and has re-opened his office for the practice of medicine at 157 Forrest Avenue, N. E., Atlanta.

The Ware County Medical Society meeting was held at the Okefenokee Golf Club, Waycross, December 6. Members and their wives were the guests of Dr. and Mrs. W. F. Reavis and Dr. and Mrs. L. W. Pierce at a barbecue dinner. Officers for 1946 are: Dr. T. J. Ferrell, president; Dr. Lewis Oden, vice-president; Dr. L. W. Pierce, secretary-treasurer; Dr. W. F. Reavis, delegate to the Medical Association of Georgia annual session at Macon, Dr. C. A. Witmer, alternate delegate, and Dr. B. R. Bussell, member of the Board of Censors.

Dr. Frank Holder, Eastman, recently released from the Medical Corps of the U. S. Army, has re-opened The Clinic at Eastman for the practice of medicine and surgery.

Dr. John L. Jacobs, Atlanta, announces the opening of his office for the consultation and treatment of allergic diseases, 421 Loew's Grand Building, 157 Peachtree Street, N. E., Atlanta.

Dr. Dan A. Jardine, Douglas, recently released from the Medical Corps of the U. S. Navy, announces the re-opening of his office for the practice of medicine on North Peterson Avenue, Douglas.

The members of the Walker-Catoosa-Dade Medical Society were entertained by Dr. and Mrs. D. W. Hammond at their home in LaFayette with a barbecue dinner on December 11. Dr. Hammond, the retiring president of the society, presided. Dr. G. P. Haymore, of Chattanooga, Tenn., read a paper, "Heart Trouble and Its Treatment." 1946 officers are: Dr. Fred H. Simonton, Chickamauga, president; Dr. Charles Stephenson, Ringgold, vice-president; Dr. Frank O'Connor, Rossville, secretary-treasurer; Board of Censors: Drs. D. W. Hammond, R. M. Coulter, S. B. Kitchens, and Dr. Frank O'Connor. Dr. Fred H. Simonton was elected a delegate to the State Association meeting.

Dr. C. L. Howard, Pelham, recently discharged from the Medical Corps of the U. S. Army, announces the opening of offices at Pelham for the practice of medicine.

Dr. James Laurice Jennings, Atlanta, announces the re-opening of his offices, after returning from foreign service in the armed forces, for the treatment of eye, ear, nose and throat diseases, 157 Forrest Avenue, N. E., and 1704 Lakewood Avenue, Atlanta.

Dr. H. Walker Jernigan, Atlanta, having returned from active service with the U. S. Navy, announces the re-opening of his office with Dr. Thomas P. Goodwyn, 710 Doctors Building, 478 Peachtree Street, N. E., Atlanta. Practice limited to bone and joint surgery.

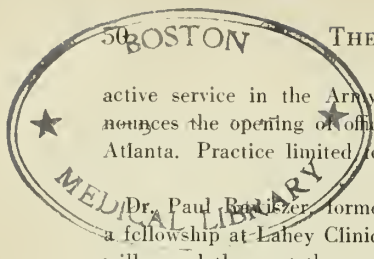
Dr. M. S. Levy, popular Augusta physician, has left for a much needed rest at a sanatorium, after remaining at his post ministering to the sick during all the arduous war years.

Dr. R. Morris Paty, Jr., Atlanta, associate dean of Emory University School of Medicine, has resigned to return to medical service with the Stephenson Memorial Hospital in Changshow, China.

Dr. W. Loomis Pomeroy, Waycross, having returned from active service with the Army Air Forces, announces the opening of his offices and will be associated with Dr. W. F. Reavis and Dr. Lovick Pierce, of Waycross.

Dr. John E. Porter, Savannah, recently discharged from the U. S. Army after more than three years of active service, will resume the practice of medicine at Savannah.

Dr. Dewey T. Nabors, Atlanta, having returned from



active service in the Army of the United States, announces the opening of offices at 902 Candler Building, Atlanta. Practice limited to urology.

Dr. Paul Radtke, formerly of Jasper, has accepted a fellowship at Lahey Clinic in Boston, Mass., where he will spend the next three years in the postgraduate department of the clinic studying neuro-surgery.

Dr. H. L. Barrow, Macon, has been appointed as school physician, Dr. R. Frank Cary, city-county health officer announced. Dr. Barrow will assist Dr. Cary in the current examination of the approximately 18,000 school children in Macon and Bibb County.

Dr. C. J. Roper, Jasper, who was recently released from the U. S. Air Corps, is re-opening offices at Jasper for the practice of medicine.

Dr. W. P. Rhyne, Albany, having returned from active service with the U. S. Army, having served more than five years with the Army Air Forces, announces the re-opening of his office at Albany. Practice limited to the diseases of the eye, ear, nose and throat.

Dr. S. E. Sanchez, of Barwick, has been selected to receive the 1945 Kiwanis award for outstanding and unselfish service to the community. Dr. Sanchez is the man of the year in Brooks County. The award is a plaque of bronze and will be presented at a public ceremony.

Dr. Myer M. Schneider, Savannah, recently discharged from the Medical Corps of the U. S. Army, announces the opening of his offices at 12 Taylor Street, West, Savannah, for the practice of medicine.

Dr. W. G. Simmons, Sylvania, recently discharged from the Army Air Forces, announces the opening of offices in the Hill Building, Sylvania, for the practice of medicine.

Dr. Duncan Shepard, Atlanta, announces the opening of his offices at 864 Juniper Street, N. E., Atlanta. Practice limited to surgery.

Dr. J. Gregg Smith, Savannah, recently discharged from the Medical Corps of the U. S. Navy, announces the re-opening of his offices at 22 West Gaston Street, Savannah. Practice limited to urology.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, January 22. Paper: "Neurologic Therapy," by Dr. W. A. Risteen, University Hospital, Augusta.

Dr. Frank Thomas, Albany, recently released from the U. S. Navy Medical Corps, has resumed his practice of medicine at Albany.

Dr. Allan C. Thurmond, Augusta, having returned from active service with the Medical Corps of the U. S. Army, has resumed his medical practice at 1345 Greene Street, Augusta.

Dr. Wilborn E. Upchurch, Atlanta urologist, serving the Navy as chief of surgery at a base hospital in the Pacific area, has been promoted to commander.

Dr. Howard V. Williams, Jr., of Macon, serving with the U. S. Army Medical Corps, has been promoted to captain. He is now stationed at Percy Jones Convalescent Hospital, Battle Creek, Michigan.

Dr. Charles Roy Williams, Wadley, recently discharged from the Medical Corps of the U. S. Army, has re-opened his office for the practice of medicine at Wadley.

Dr. Olin H. Weaver, Macon, one of the city's outstanding surgeons, has been re-appointed chief of the surgical service at the Macon Hospital, according to a list of 1946 appointments announced by Dr. C. L. Ridley, hospital superintendent. Dr. J. C. Anderson was named chairman of the executive committee, which includes Drs. C. N. Wasden, M. B. Hatcher, O. H. Weaver and R. G. Newton.

Dr. Webb Conn, Brunswick, well known physician, who retired from practice six months ago because of ill health, has greatly improved and has resumed his practice of medicine at Brunswick.

Dr. A. D. Williams, Folkston, announces the completion of a modern new clinic and office building at Folkston. With the latest and most modern instruments and equipment for diagnosis and treatment, the clinic adds greatly to the medical facilities available to the people of Folkston and surrounding area.

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. For information address—Dr. Jas. R. Bloss, secretary, 418 11th Street, Huntington 1, West Virginia.

Dr. Joe Williams, Augusta physician, recently discharged from the armed services, has been named as police and fire department surgeon of Augusta.

Dr. L. A. Smith, Quitman, was appointed county physician to succeed Dr. T. R. Moye whose health does not permit him to serve, at the recent meeting of the Brooks County Board of Commissioners.

Dr. M. W. Williams, Camilla, recently released from the Medical Corps of the U. S. Army, has re-opened his office for the practice of medicine at Camilla.

Dr. James T. King, Atlanta, after five years with the United States Army Air Forces, announces his association with Dr. Leon E. Brawner, Suite 803 Medical Arts Building, Atlanta. Practice limited to diseases of the ear, nose and throat.

Dr. David Henry Poer, Atlanta, recently promoted to a full colonel, has taken up his duties as chief surgical consultant for the Fifth Service Command Area, Fort Hayes, Columbus, Ohio. He is responsible for the welfare and surgical treatment of 1,500 patients, and has a staff of 37 Army surgeons under his leadership.



The Floyd County Medical Society held its quarterly meeting at the Floyd Hospital, Rome, December 19. Officers for 1946 are: Dr. Robert Norton, president; Dr. Ralph B. McCord, vice-president; Dr. Lee H. Battle, secretary-treasurer; Dr. J. T. McCall, delegate to the 1946 annual session of the Medical Association; Dr. Robert Harbin, alternate delegate.

Col. Daniel C. Elkin, Atlanta, an Army medical officer for three years and well-known surgeon, has returned home and will resume his position as the Joseph B. Whitehead professor of surgery at Emory University School of Medicine, Atlanta, a position created only recently by funds donated to the school.

Dr. Hubert Milford, Hartwell, recently discharged from the Medical Corps of the U. S. Army, announces the re-opening of his offices for the practice of medicine at Hartwell.

Dr. Goodrich C. White, president, Emory University School of Medicine, Atlanta, with the approval of the university's executive committee, announces nine new faculty members. They are: Dr. Frank L. Engel, associate professor of medicine; Dr. Max Michael, assistant professor of medicine; Dr. Harry Lee Allan, assistant professor of anatomy; Dr. Albert Louis Evans, Dr. William Parker Leonard, and Dr. Virgil Duncan Shepard, all assistant professors in the department of surgery; Dr. James Thomas King and Dr. Buford Lee O'Neal, assistant professors in clinical otorhinolaryngology. Miss Else Kristensen becomes an instructor in medical and surgical nursing in the School of Nursing.

Dr. W. L. Curtis, College Park, recently discharged as a Flight Surgeon in the U. S. Army, after more than three years of active duty, announces the re-opening of his offices in the Timms Building, College Park, for the practice of medicine.

Dr. Roy Johnson, Jr., Thomson, has returned after more than three years with the Fleet Marine Force as Flight Surgeon, and has been released to inactive duty in the U. S. Naval Reserve. He has re-opened his office for the practice of medicine at Thomson.

Dr. L. M. Freedman, Savannah, has returned from the European Theater of War, where he served in the Medical Corps of the U. S. Army, and announces the opening of his office at 1½ East Gordon Street, Savannah, for the practice of medicine.

Emory University will hold an ophthalmologic seminar April 4, 5, 6, honoring the memory of the late Dr. Abner Wellborn Calhoun. Guest lecturers: Drs. William Benedict, John Dunnington, Parker Heath, Walter Lillie, Derrick Vail, and Frank Walsh. All members of the ophthalmologic profession are cordially invited as guests of Emory Hospital. Make reservations early at the Atlanta Biltmore Hotel, Atlanta.

Dr. Charles H. Richardson, Jr., Macon, announces the opening of his office for the practice of general surgery, in association with his father, Dr. Charles H. Richardson, Sr., 700 Spring Street, Macon.

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the hospital dining

room January 10. After the election of officers Dr. L. Minor Blackford gave a talk on "Cirrhosis."

Tulane University of Louisiana School of Medicine, Department of Graduate Medicine, 1430 Tulane Ave., New Orleans, La., announces review of general medical practice: March 11-16, 1946, Diseases of the Cardiovascular System; March 25-30, Plumonary Diseases; April 1-6, No Classes; April 8-13, Urinary Diseases; April 15-20, Diseases of Nervous System; April 22-27, Nutritional and Metabolic Diseases; April 29-May 4, Infectious Diseases; May 6-11, Neoplastic Diseases; May 13-18, Obstetrics and Gynecology; May 20-25, Traumatology.

Dr. Henry D. Holliman, Jr., Atlanta, announces the opening of his offices, 864 Juniper Street, N. E., Atlanta. Practice limited to urology.

Dr. J. Harry Lange, Atlanta, announces his return from military service and the resumption of pediatric practice at 104 Ponce de Leon Avenue, N. E., Atlanta.

Captain William M. Cason, USNR, of Sandersville, has been appointed as senior medical officer of the U. S. Naval Air Station dispensary, Atlanta, announced Captain E. T. Neale, commanding officer of the station.

Dr. Alexander G. Little, Jr., Valdosta, recently received his discharge from the Medical Corps of the Army and is practicing medicine with his father, Dr. A. G. Little, at the Little-Griffin Hospital, Valdosta.

The St. Joseph's Infirmary medical staff, Atlanta, met in the hospital cafeteria, January 22. New officers for 1946 were elected. They are: Dr. Mason Lowance, president; Dr. Julian Riley, president-elect; Dr. Sterling Claihorne, vice-president; and Dr. Bernard Wolff, secretary.

Dr. Howard J. Morrison, Savannah, recently released from the Navy Medical Corps after more than three years of service, has announced the re-opening of his office for the practice of medicine at Savannah.

#### OBITUARY

*Dr. Frank M. Bruce*, aged 63, prominent Homerville physician, died in a Waycross hospital, Dec. 22, 1945. He was a native of Wilcox County, and made his home in Homerville since 1926. Dr. Bruce was graduated from the Maryland College, Baltimore, in 1904. He was a member of the Ware County Medical Society, the Medical Association of Georgia, the American Medical Association, Clinch County Board of Health, and chairman of the Board of Deacons and member of Homerville Baptist Church. Survivors are six daughters, Mrs. Allen H. Finleyson, Mrs. Alton Smith, Mrs. John Ferdon, Homerville; Mrs. J. P. Baldree, Cleveland, Tenn.; Mrs. James Trichler, Atlanta; and Mrs. Walter Zukowski, Brooklyn, N. Y. Four sons, Frank M. Bruce, Jr., U. S. Army overseas; J. N. Bruce, U. S. Navy; Lt. W. W. Bruce, Camp Shelby, Miss.; Richard L. Bruce U. S. Navy, Pearl Harbor; 15 grandchildren, three sisters and four brothers. Funeral announcements are pending the arrival of his sons from overseas.



*Dr. J. J. Johnson*, aged 78, of LaFayette, died at his home, Dec. 17, 1945. He was graduated from the Atlanta Medical College, and began the practice of medicine in Chattooga County, moving to LaFayette in 1904, and for more than forty years practiced in Walker and Chattooga counties before his retirement six years ago. Dr. Johnson was a Mason, and was a past master of Gordon Springs lodge. He is survived by his daughter, Mrs. Sam Reed, LaFayette; a son, Joseph Virgil Johnson, Atlanta; one sister, Mrs. H. J. Spencer, Chatanooga Valley, and a granddaughter, Miss Catherine Johnson, Atlanta. Funeral services were held at the Concord Methodist Church.

*Dr. Wallace D. Kennedy*, aged 73, died at the Kennedy Memorial Hospital, Metter, Dec. 28, 1945. He was graduated from the Emory University School of Medicine, Atlanta, in 1891. He was one of the oldest practicing physicians and surgeons in the South, having started practicing at the age of 20 in Bulloch County, near Brooklet. He later moved to Metter and formed a partnership with his father, the late Dr. Dan Kennedy. In 1924 he and his son, Dr. R. L. Kennedy, formed a partnership and later built the Kennedy Memorial Hospital, one of the most modernly-equipped hospitals in the State. Dr. Kennedy was a member of the Bulloch-Candler-Evans Medical Society, the Medical Association of Georgia, the American Medical Association, and the Metter Primitive Baptist Church. He is survived by his wife, Mrs. Vertie Trappnell Kennedy; one son, Dr. R. L. Kennedy; two daughters, Mrs. Minnie Lee Dekle, Metter; and Miss Jane Kennedy, Akron, Ohio; two grandsons, Kennedy Dekle, U. S. Navy; and Robert Lewis Kennedy. Funeral services were held from the Metter Primitive Baptist Church, with Elders V. F. Agan and J. Walter Hendricks officiating. Burial was in Lake Cemetery.

*Dr. George Wiley King*, aged 74, of Atlanta, died at his residence Jan. 12, 1946. Dr. King, a native of Jackson, La., was graduated from the University of the South Medical School, Suwanee, Tenn., in 1896. After graduation he practiced medicine at Thomaston and Manchester, and for the past 20 years was a leading practitioner of Atlanta. He was a member of Grace Methodist Church. Survivors include his wife; a daughter, Mrs. Mary Ellen Bell, Atlanta, and a sister, Mrs. J. J. Stevens, Atlanta. Funeral services were held held at Spring Hill, with Rev. C. Byrd Harbour officiating. Burial was in Bethesda churchyard, Manchester.

*Dr. Julius Shuford Mitchell*, aged 72, retired practitioner of Rome, died Dec. 28, 1945. Dr. Mitchell was born in Rome, the son of the late Dr. R. V. and Addie Stokes Mitchell. He was graduated from Vanderbilt University School of Medicine, Nashville, in 1894. He was a member of the First Methodist Church, Rome. He is survived by his wife, Mrs. Mable Faulk Mitchell; two daughters, Mrs. W. J. Hutchins and Mrs. L. D. Carson; two sisters, Misses Estelle and Addie Stokes Mitchell. Funeral services were conducted from the chapel of Daniel and Son Funeral Home, with Rev.

Claude Hendrick, pastor of the First Methodist Church, officiating. Burial was in Myrtle Hill Cemetery.

*Dr. Charles Washington Reid*, aged 78, Pelham's oldest and beloved physician, died suddenly at his home, Jan. 1, 1946. He was born at Friendship in Sumter County and graduated from Atlanta Medical College, now Emory University School of Medicine, Atlanta, in 1882. He began the practice of medicine in Macon County, but soon moved to Pelham, and for more than a half century devoted his time and talents to the service of the people in Mitchell and adjoining counties. Dr. Reid in recent years had specialized in electrical therapy, and up to the day of his death maintained his daily office routine. He was president and secretary of the Mitchell County Medical Society, member of the Medical Association of Georgia, the American Medical Association, charter member of the Pelham Board of Education, and Pelham Lodge No. 312 F. & A. M. In 1884 he married Miss Marion Murray of Macon County, who died in 1917. The only survivors are his daughter and son-in-law, Mr. and Mrs. John Monaghan of Pelham. Funeral services were held at the home, with the Rev. Bernard L. Brown, pastor of the Hand Memorial Methodist Church, officiating. Burial was in the local cemetery.

*Dr. William Thomas Smith*, aged 69, Tifton physician, died at the Tift County Hospital, Dec. 8, 1945. Dr. Smith was born in Crawford County and graduated from George Washington University School of Medicine, Washington, D. C., in 1899. He did general practice at Culloden for one year and then went to Tallahassee, Fla., where he practiced until 1906, when he moved to Tifton. He was a member of the Tift County Medical Society, the Medical Association of Georgia, and the American Medical Association. Surviving are his widow, Mrs. Maude Burns Smith; a son, William T. Smith, Jr., of Tifton; two daughters, Mrs. H. E. Killian, Aniston, Ala.; Mrs. Dave Howard, Athens; three brothers, Howard P. Smith and Robley D. Smith, Tifton, and Northrop Smith, Macon. Funeral services were held at the residence with Rev. L. E. Williams, pastor of the First Methodist Church, and Rev. Davis M. Sanders, pastor of the First Baptist Church, officiating. Burial was in the local cemetery.

#### FLU VACCINE AVAILABLE FOR CIVILIAN USE

Influenza vaccine of the kind given to all Army personnel is now available for civilian use.

The vaccine is effective against Types A and B influenza, which have caused epidemics in recent years. Other types of influenza virus exist. Authorities do not know whether the world-wide influenza epidemic in 1917-1918 was due to A or B virus or to some other type.

Army studies, prior to the general vaccination order, showed that about 75 per cent of those vaccinated were protected against influenza during outbreaks which occurred soon after the vaccination. How long the immunity, or protection, lasts is not definitely known.

### SURPLUS PROPERTY

Any physician who served in the active Army or Navy service in the present war and has been honorably discharged, may apply for a preference to buy surplus medical goods directly from the government. Heretofore, surplus has been sold only through established retailers. Preferences are obtained from the Surplus War Property Custodian in the district in which the physician intends to practice. SWPC handles only equipment worth less than \$2,500.

### ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of \$300, and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Chicago, Illinois in April or May 1946, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3000 words in length; must be presented in English; and a type-written double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia not later than February 20, 1946. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the Association. This will not prevent its further publication, however, in any journal selected by the author.

### AMERICAN UROLOGICAL ASSOCIATION AWARD

The American Urological Association offers an annual award 'not to exceed \$500' for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the secretary for full particulars.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, Ohio, July 22-25, 1946.

Essays must be in the hands of the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before July 1, 1946.

### PENICILLIN FOR UNRRA

The miracle drug, penicillin, will be continuously available in several European countries as result of improved arrangements, it was announced recently.

In at least three countries, and possibly more, the

governments will set up plants to manufacture the drug, under plans obtained and supplied by UNRRA and this agency will supply necessary component parts for the manufacturing process.

Czechoslovakia, Poland, and Yugoslavia will set up the first plants, under government ownership and operation, and other countries may join in the program later, though this has not yet been decided. The plans supplied by UNRRA to the countries are designed to implement production of 15 to 20 billion units of the drug each month from each factory.

### DIRECTORY OF APPROVED SURGICAL TRAINING PLANS PUBLISHED BY AMERICAN COLLEGE OF SURGEONS

Chiefly as an aid to medical officers returning from war duty, the American College of Surgeons has published a 424-page directory in which are listed and described the approved programs of graduate training in surgery in 240 civilian hospitals in the United States and Canada, and in 32 Naval, 7 Veterans Administration, and 10 United States Public Health Service hospitals.

The total number of approved training plans in the 289 hospitals is 228 in general surgery and 522 in the surgical specialties—fractures, plastic surgery, proctology, thoracic surgery, neurologic surgery, orthopedic surgery, urology, obstetrics and gynecology (combined and separately), and ophthalmology and otolaryngology (combined and separately). In these 750 training plans in 289 hospitals, approximately 2,000 surgeons may be trained, whereas, as the college points out, training facilities for at least 5,000 are urgently needed for returning medical veterans whose training in surgery was interrupted by their military service. Publication of the directory is expected to stimulate the formation of additional programs of training in suitable hospitals, according to Dr. Irvin Abell, chairman of the Board of Regents.

The approved programs of graduate training in surgery in civilian hospitals are located in the following states and provinces: Alabama, 3; California, 12; Colorado, 1; Connecticut, 2; District of Columbia, 5; Georgia, 3; Illinois, 16; Indiana, 4; Iowa, 1; Kansas, 1; Kentucky, 2; Louisiana, 3; Maryland, 16; Massachusetts, 13; Michigan, 16; Minnesota, 9; Missouri, 12; New Jersey, 5; New York, 40; North Carolina, 2; Ohio, 17; Oklahoma, 1; Oregon, 4; Pennsylvania, 23; South Carolina, 1; Tennessee, 4; Texas, 6; Virginia, 5; West Virginia, 1; Wisconsin, 4; Ontario, 4; Quebec, 4. Additional approved programs will be published from year to year in the approval number of the college bulletin.

### PEDIATRIC ANTIQUES ON TOUR

It has been well said that more progress has been made in pediatrics during the past three or four decades than in all the time before that.

As applied to the feeding part of pediatrics, the Mead



Johnson Collection of Pediatric Antiques bears eloquent witness to the great strides made. Without such evidence, it would be difficult, indeed, to imagine our own grandparents being fed from some of these odd-shaped utensils that defied thorough cleansing. To be sure, sterilization and pasteurization were not then in vogue. Not all babies received breast milk in abundance. In the days when wet nurses were common, some of these enterprising women literally did a wholesale business, managing to nurse three or four infants.

The baby's cereal of a century ago was simply stale bread lightly boiled in water, wine or beer. Butter or sugar might be added but the use of milk was regarded as fraught with danger. It was thought, according to Dr. T. C. H. Drake, "Milk might bring on the watery gripes, or the infant might imbibe with the milk the evil passions and frisky habits of the animal supplying the milk."

From a personal hobby enjoyed by the late E. Mead Johnson, Jr., the Collection of Pediatric Antiques, illustrated in the pages of a catalog just issued, has evolved into one of considerable historic importance, depicting as it does the progression of infants' feeding vessels from the Greece of twenty-five centuries ago down to time within our own memory.

The collection has been steadily growing in size and scope and is of increasing interest for teaching purposes via the historical route. The destruction of original sources caused by the war tends to add to the value of these objects.

Hence it is that, by request, the collection now goes on an annual pilgrimage to colleges, hospitals, museums, libraries and other institutions of learning. Arrangements may be made for "stop-overs" upon application to the curator, Mead Johnson & Company, Evansville 21, Indiana.

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#### THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The New Orleans Graduate Medical Assembly, ninth annual meeting, will be held in New Orleans, April 1-4, at the Municipal Auditorium. The program will consist of lectures by sixteen outstanding guest speakers, clinics, symposia, clinico-pathologic conferences, round-table luncheon discussions and technical exhibits. Registration fee of \$10.00 covers all features, including three luncheons. Physicians who plan to attend are invited to register at once with the secretary, Room 105, 1430 Tulane Avenue, New Orleans 13, Louisiana. Information regarding hotel reservations will be sent upon receipt of registration fee or by request.

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#### NEW FILM-VIEWER

This film-viewer has been developed by the Fairchild Camera and Instrument Corporation, Jamaica, N. Y., to make it possible for x-ray specialists to read 350 to 400 x-ray negatives on 100-foot rolls of 70 mm. film conveniently and rapidly. The rolls of chest x-ray negatives are made in the Fairchild Fluoro-Record camera,

developed and dried in Fairchild-Smith processing equipment, then re-spooled for reading in the viewer.

In reading the film, the radiologist scans through the roll, keeping the film in slow, continuous motion. This rapid scanning is usually done without magnification, until the physician spots a suspicious negative. Then he swings the lens into position and studies the negative, under magnification, to ascertain if the subject is tuberculous. The reading is frequently done in a dimly-lighted room and the light shining out of the louvre on the side of the viewer provides just enough illumination on the table to allow the doctor to make notes on the record cards as he studies the negatives.

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#### THE A. P. A. A. (NINTH) 1947 EXHIBITION

To be held at Atlantic City, on the occasion of the Centennial Session of the American Medical Association, will also be the occasion of the judging of the "courage and devotion beyond the call of duty" art prize contest (\$34,000 in savings bonds).

This contest was originally scheduled for the 1946 A. M. A. session but has been postponed one year, upon the best advice, in order to give more physicians an additional year to complete their art pieces on this special prize subject.

For further information regarding both the San Francisco, 1946, and the Atlantic City, 1947, Art Exhibits, physicians may write either the American Physicians Art Association secretary-treasurer, Dr. Francis H. Rodewill, Flood Building, San Francisco, Cal., or the sponsor, Mead Johnson & Co., Evansville 21, Ind.

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#### MISSISSIPPI VALLEY MEDICAL SOCIETY 1946 ESSAY CONTEST

The Mississippi Valley Medical Society is resuming its annual Essay Contest which has not been held during the war. In 1946 it offers a cash prize of \$100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society to be held at St. Louis, Mo., September 25, 26, 27, 1946, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall not exceed 5000 words, be typewritten in English in manuscript form, submitted in five copies and must be received not later than May 1, 1946.

Further details may be secured from

HAROLD SWANBERG, M.D., *Secretary*,  
Mississippi Valley Medical Society,  
209-224 W. C. U. Building, Quincy, Illinois.



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## BASIC PRINCIPLES IN THE TREATMENT OF CANCER

J. L. CAMPBELL, M. D.  
*Atlanta*

The following conclusions are based on observations made during my service as chairman of the Cancer Commission of the Medical Association of Georgia, many years work in the outpatient clinic and wards of Grady Hospital, eleven years as director of the Sheffield Clinic at the Georgia Baptist Hospital, and in private practice.

Many cancer patients can be salvaged. Those with advanced disease can be made more comfortable, a few of the moderately advanced ones can be cured, and a majority of early cancers may be permanently cured if properly and promptly treated.

Cancer is a unique disease. The primary cause has not been discovered; yet we know a great deal about it. We know that it begins when a single body cell or small group of cells fail to differentiate into normal tissue and take on abnormal activity. They throw off the restraint governing growth, and multiply without regard to the law of nature. They infiltrate the surrounding tissues and push their way into the lymph spaces and vessels to be carried to the regional lymph nodes where they lodge for a time before penetrating the blood vessels to be distributed to distant and inaccessible parts of the body. We know all of these things, and there are few exceptions to the rule.

The ultimate results in the treatment of cancer depend on early diagnosis, the grade of the cell, the rate of growth, the age and physical condition of the individual, the lymph and blood supply, and the muscular activity of the part involved. A thorough knowledge of the lymph drainage area by

the attending surgeon or radiologist, the method of treatment and the skill with which it is applied also determine the ultimate outcome. The surgeon or radiologist must consider the framework of the organ or part, the extent and character of the infiltration, the blood and lymph drainage area, and then govern his procedure accordingly.

A definite diagnosis should precede treatment. It is, therefore, necessary in the majority of cases to make a biopsy before beginning treatment either by surgery or irradiation. If a diagnosis can be made clinically, the disease is usually too far advanced to be greatly benefited. Biopsy should be made as short a time as possible before treatment is instituted. In areas richly supplied by lymphatics it is best to have the patient prepared for operation with a pathologist present to give an opinion. It has been our observation that the removal of enlarged lymph nodes for histologic study in order to diagnose the primary lesion, even though the nodes are in the immediate drainage area, may not always be a safe diagnostic procedure, as hyperplasia precedes actual invasion.

In a discussion of this scope it is impossible to outline one's views in regard to the treatment of cancers in all parts of the body, consequently only those in the most accessible parts will be considered.

Cancer of the skin made up 47.3 per cent of the lesions in 6,887 patients treated in Georgia's State-aid cancer clinics since 1937 and, therefore, deserves consideration. It is hoped that some of our dermatologists will see fit to discuss this subject at an early date. Many skin cancers yield to surgery, especially small ones with raised, well defined margins. These can be removed by an elliptical incision carried far enough afield and sufficiently deep to get

all infiltrating cells. A skin cancer on the back of the hand, if adherent to the underlying fascia, will require the removal of a part or all of the hand because the cells may have penetrated the interosseous muscles and will be stimulated, rather than cured, by simple removal. Skin cancers with soft, ill defined margins should be treated by irradiation in preference to surgery. Melanotic moles and early malignant melanomas should be treated by wide deep excision. *Never* use coagulation, fulguration, or cautery. Advanced melanomas are best left alone. Keratoses can be cured by irradiation or coagulation.

More than 200 cancers of the lips and the buccal cavity have come under our observation at the Sheffield Clinic, Atlanta, since 1934. The majority were located on the lower lip. If such lesions are seen before the full thickness of the lip is involved, and when the lymph drainage area shows no evidence of metastases, irradiation is the treatment of choice. However, when they are further advanced, surgery should be employed. If properly done very little deformity of the face will result; even in advanced cases good cosmetic results may be obtained.

Cancer of the inner surface of the cheek, in the angle between the gums and cheek and the floor of the mouth, is extremely difficult to cure unless seen very early. Even then results may be disappointing. X-ray in very large doses, with occasional thorough cauterization, is the treatment of choice. Radium needles, or radon, properly implanted, have given good results in some cases, but my experience has not warranted recommendation of this method.

Cancer of the tongue, if seen early, can be cured by surgery in a moderate number of cases. Radium needles and radon in the hands of experienced operators have given good results. Whatever the method of treatment very radical procedure is necessary. Preoperative x-ray should be given unless the lesion is small and seen very early. Postoperative x-ray, or preferably a radical dissection of the neck, is absolutely necessary where there is involvement of the cervical nodes.

A radical block dissection of the neck is useless unless it removes the lymph-bearing tissue in the submaxillary region and the submaxillary salivary gland, the sternomastoid muscle, the sheath of the carotid vessels, the internal jugular vein from just below its exit from the skull to the clavicle with the lower pole of the parotid gland and all the deep cervical fascia. This is a tedious and time-consuming operation but is justified by end results. Anything less will be a failure.

A little more than 20 per cent of the 6,887 cancers treated in the 11 State-aid clinics were located in the female genital organs, cancer of the cervix forming the vast majority. My personal experience has been confined to the Sheffield Clinic cases and to private practice. However, we have seen every imaginable variety of lesion, from the earliest ulcer on the cervix to complete infiltration and "freezing" of all the pelvic organs with destruction of the vagina and external genitalia.

Unfortunately, the early symptoms are obscure, varying from intermenstrual spotting after the slightest trauma to excessive hemorrhages. A few rather advanced cases are discovered by accident during a routine examination for some other malady.

At the Sheffield Clinic the cases are classified as nearly as possible into three groups and after examination are referred to the radiologic division, of which Dr. O. D. Hall is the director.

GROUP 1: Where the infiltration has not extended beyond the cervical tissue. Whether the primary lesion is an ulcer on the lips of the cervix, in the cervical canal or of the papillary type, just so there is no palpable thickening in the broad ligaments we feel that the patient is amenable to treatment with radium in large doses at 5 to 6 weeks' interval. If the lesion is of the papillomatous type we cut it away with an electric loop before applying the radium. Perhaps 80 per cent of this group can be cured.

GROUP 2: Where there is palpable thickening around the cervix but the uterus is not yet fixed. In such cases we feel that a series of perhaps 2,500 to 3,000 R-units of x-ray should be given previous to the application of radium. The dose of radium may be somewhat reduced but still should be sufficient to get a full reaction. By careful attention to detail and follow-up 50 per cent of this group may be salvaged.



GROUP 3: Where the pelvis is frozen or the disease is located in the vagina or labia and is advanced. Under these circumstances nothing but palliation can be expected. Large doses of x-ray often relieve the pain and make life more bearable.

Bony metastases are also placed in this group because nothing more than palliation can be expected; then later a bed in the Hospital of our Lady of Perpetual Help, Atlanta.

Now and then a surprising result can be obtained, so we must not paint too gloomy a picture.

Since the organization of the Sheffield Clinic in 1934 478 cancers of the uterus have been seen: 319 (67 per cent) have been treated with radium.

Among the State-aid cases 10.5 per cent have been located in the mammary gland. Again, the extent of the lesion is variable. Fortunately, more women are applying for advice for non-malignant lesions than ever before, showing that our campaign of education and the advantages offered indigent people by our State-aid program are bearing fruit.

Following the classification of Pfahler we divide the cases into three groups:

GROUP 1: Where there is a non-adherent lump with no axillary nodes palpable, we prefer surgery without preoperative x-ray. Where the lesion is small we remove the tumor with considerable surrounding breast tissue as a diagnostic measure. If the pathologist gives a negative report the wound is closed. Where the tumor is larger, the entire breast is removed for examination. If the lesion is malignant a radical operation is completed; if non-malignant the wound is closed as a simple mastectomy. When the pathologist finds that there are involved nodes in the axillary fat postoperative x-ray treatments are given.

GROUP 2: Where the lesion is more advanced, with palpable axillary nodes, preoperative x-ray is given in large doses. If there is a favorable reaction a simple mastectomy or a radical operation is done according to the age and condition of the patient.

GROUP 3: On advanced cases x-ray treatment alone is advised, as we feel it is impossible to remove all the involved tissue. Only occasionally is surgery resorted to where there is exceptional recession after x-ray therapy and no bony or visceral metastases are demonstrable.

Some of the factors that influence the prognosis are well worth considering. When cancer occurs in a young individual, during pregnancy or lactation, and in women ex-

cessively fat, the prognosis is grave indeed. But, as in uterine cases, the unexpected sometimes occurs and it is well enough to undertake treatment after forewarning both the family and the patient of the unpredictable results.

There have been 367 breast cancers treated at the Sheffield Clinic. Among these every stage of involvement has been encountered. It is astonishing that people living in the present age will permit a lesion to progress to the extent that we find in some seemingly intelligent people. The excuse is almost invariably the statement: "It was not tender and gave no pain. I thought it would disappear and forgot about it." In early cases it is hard to make a woman believe she has a serious condition because it has not been painful!

To illustrate the value of treatment, an unusual carcinoma of both breasts and 2 primary cancers of the clitoris are reported:

#### REPORT OF CASES

*Case 1.* Mrs. R., cancer of both breasts, aged 35, weight 100 lb., two children, the elder of whom died in infancy. She noticed a lump and experienced fullness in the left breast when her youngest child was two weeks old. Usual treatment was only partly successful in clearing it up. I saw her when the baby was about two years old.

At that time (October, 1943) the breast was completely infiltrated and frozen to the chest wall, but with the axillary nodes still discrete. It presented the usual orange peel skin of the inflammatory type of breast cancer. She was sent to Dr. W. F. Lake for x-ray treatments. In about two months the breast had become fibrous, was fairly movable, and the axillary nodes had disappeared. As the recession was so favorable, a complete Halsted operation was done.

Five months later she came in with the right breast in the same condition as the left one had been when first seen. The treatment was repeated and the breast was removed as soon as the x-ray reaction was complete. The pathologic report was the same as in the other breast.

About three or four months later she noticed several nodes in the skin of the back of her neck. X-ray treatments did no good. Later there were numerous nodes over the trunk and inguinal region. One was removed for histologic study. Dr. Funke reported that it was a simple fibropapilloma; no cancer cells were found.

About eighteen months after the first operation several masses were found in the mid-abdomen. These proved to be fecal impactions, the result of partial obstruction due to a stricture of the rectum and a "frozen pelvis." Measures to relieve the impactions were suc-



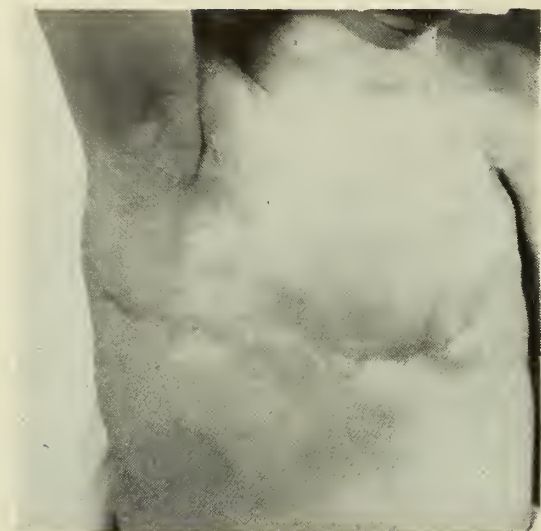


FIGURE 1

Carcinoma of both breasts, the first appearing when last child was 8 weeks old. Eighteen months later the breast was infiltrated and "frozen" to the thorax. X-ray therapy produced fibrosis and melting of the axillary nodes. A Halsted amputation was done. About a year later the right breast went through the same process. Good local results were obtained but she developed extensive metastases.

cessful and x-ray therapy has almost completely cleared up the pelvic infiltration, and greatly relieved the stricture of the rectum. The skin nodes have also almost disappeared. At the present she has involvement of the pelvic and lower lumbar vertebrae and the upper ends of both femurs. She is getting some low back pains. There is, however, marked x-ray evidence of improvement in the bony lesions. No pulmonary involvement was found February 10, 1946.

This is the only patient with cancer of the breast occurring during pregnancy or lactation whom I have known to live longer than a few months. She is still able to travel from her home to Atlanta and walks about with comfort, though she is not strong. The arms have swollen very little and she uses them as freely as if she had both pectoral muscles.

*Case 2.* Mrs. H., primary epidermoid carcinoma of the clitoris, aged 27, married 14 years, 1 child 12 years old; 6 months pregnant when first seen. She was referred for an apparently inflamed and enlarged clitoris and enlarged inguinal nodes. She had noticed this condition for several weeks, but had attributed it to her pregnancy. She had not experienced any discomfort until ten days previous to seeing her physician, who referred her to me.

Her family history was negative except that her father had bone sarcoma, but was still living.

When she was admitted to the hospital her clitoris measured about 2 x 1.5 cm. The inguinal nodes were large and somewhat tender. The clitoris was removed and, on account of her pregnancy, she was referred to Dr. R. A. Bartholomew because she was anxious for a living child. It was thought best not to give x-ray treatments on account of the pregnancy. Sometime later the inguinal nodes were removed and found to be metastatic. She was kept under observation until Dr.

Bartholomew felt the child would be viable and then a cesarean section was done and a thorough search made for abdominal metastases. This was followed by intense x-ray treatments over the inguinal region and external genitals. She made an uneventful recovery. The child is living and well and is now nearly three years old.

*Case 3:* Primary melanoma of the clitoris. An elderly woman came to me as a State-aid clinic patient at the Georgia Baptist Hospital with a lesion of her clitoris and enlarged inguinal nodes, similar to the one just described. She received the same operative treatment as had been given Mrs. H, but unfortunately her lesion was found to be a melanoma. A local cure was obtained, but when last seen she had generalized metastasis. No report has been received recently.

### SUMMARY

An effort has been made to impress the reader with:

1. The importance of an early diagnosis of cancer.
2. The necessity of considering the character of the infiltration and the rate of growth of the primary lesion.
3. The importance of the lymph drainage area, for as John B. Murphy once said, "If it were not for the lymphatics cancer would lose a large per cent of its seriousness."
4. The danger of incomplete treatment of malignant lesions, for our observation has been that it does more harm than good.
5. The importance of classifying or grouping the cases and applying treatment accordingly.

### TUBERCULOSIS MORTALITY

Due to improved methods of case-finding and more widespread knowledge about the disease, tuberculosis did not increase in this country during the war, though it rose to alarming proportions in Europe and Asia. Nevertheless, it is deplorable that tuberculosis took more than 205,000 American lives during the war years.—Harry S. Truman.

It can be assumed that no people have a racial characteristic which makes them peculiarly susceptible to tuberculosis because of genotypic traits. Lack of exposure of any group, regardless of race, produces an extremely high incidence of tuberculosis which runs a more acute course when first introduced. After prolonged exposure, native immunity is manifest, with survival of stock resistant to the disease, and with a concomitant decline in the amount of clinical tuberculosis and the approach of saturation point of tuberculinization. With this there is noted a relative increase in pulmonary forms and an accentuation of chronicity.—J. R. McGibony, M.D., and A. W. Dahlstrom, M.D., *Am. Rev. Tbc.*, August, 1945.

## HOW PERMANENT ARE THE RESULTS OF TRANSURETHRAL PROSTATIC RESECTION?

HAROLD P. McDONALD, M.D.

ALEXANDER J. FILIP, M.D.

*Atlanta*

Early in the use of transurethral resection permanency of the results, of course, could not be foreseen. At first this method for relief of prostatic obstruction was timidly applied. Being a new procedure it was natural and proper that such caution should be exercised. On account of this caution, due to the fear of immediate or late bleeding and other complications, complete removal of obstructing tissue was rarely accomplished. In consequence the results were not as good or as lasting as had been expected, or hoped.

The resectionists who made cystoscopic examinations of the vesical neck in search of reasons for these poor results soon saw why the relief had not been afforded. The inadequate removal of the obstructing tissue was quite evident. Then by more complete transurethral resection, lasting freedom in voiding was made possible.

Later, as experience was acquired, it was possible to remove all of the obstructing part of prostates of moderate size at the first sitting. Then adequate transurethral resections of vesical neck obstructions began to afford, as a rule, almost consistently satisfactory results. These good results, however, were accomplished by the resectionists who had a good mental picture of how the vesical neck should look in order to expect free voiding subsequently. Some urologists had an aptitude for this work and the technical skill to remove the tissue as desired. Others, lacking in these qualities, failed to develop enough enthusiasm for this method to improve or perfect their technical skill. These men soon abandoned the resectoscope for all obstructions except small bars and median lobes.

In order to compare the lasting qualities of the relief afforded by the transurethral

resection of vesical neck obstructions with that obtained by suprapubic or perineal prostatectomy, one should not consider inadequate resections or inadequate prostatectomies. Those who favor open prostatectomy have removed by this method obstructing tissue left after poor resections. Others who prefer this transurethral method have corrected the poor results after open prostatectomy by transurethral removal of obstructing prostatic tissue. Obstructions left by either primary procedure may be removed subsequently by either method.

In order to obtain the opinion of other urologists concerning the permanency of transurethral resection we have written several men who have done large numbers of transurethral resections. Replies indicate that permanent good results are dependent upon complete removal of obstructing or hypertrophic prostatic tissue. To quote a few:

Dr. John L. Emmett, of the Urological Department of the Mayo Clinic, writes:

"We have done approximately 10,000 transurethral resections and my impression is that possibly 3 to 5 per cent of the resections which we have done each year for the last two or three years have been on cases that had previous resection here anywhere from four to seven years before. The reason for this, of course, is that during the years between 1933 and 1937 our resections were fairly incomplete. Since 1937 we have been gradually approaching a prostatectomy in most cases, so that my feeling is that this percentage from now on will decline."

Dr. Charles C. Huggins, Professor of Urology, University of Chicago, says:

"Certainly in our hands at least 10 per cent, I should think, of the patients develop a further difficulty, usually 3 to 5 years after the operation. Moreover, I do not believe that it is possible regularly to remove all of the adenomatous tissue by this operation, and in certain of the patients the tumor will again grow. We base this opinion on an observance of approximately 2,000 operations of this type."

Dr. Reed M. Nesbit, Professor of Urology, University of Michigan, Ann Arbor, who has performed about 4,500 resections writes:

"I think of this situation a great deal because, like all people who have been doing transurethral resections for a long time and in a considerable number of cases, I see patients occasionally who have previously had transurethral resection and who develop recurrent prostatic enlargement and recurrent obstruction. I think that any surgeon who performs transurethral resection would be indulging in foolhardy wishful thinking to believe that he removes all of the prostate gland. To be sure





FIGURE 1

This shows 120 grams removed, representing approximately 90 per cent of the prostate gland. The 2-ounce medicine cup is shown for comparison.



FIGURE 2

Permanent results assured by adequate removal of prostate. This shows 140 grams removed from one patient, representing approximately 90 per cent of the gland.



the modern resectionist exposes the prostatic capsule and makes every effort to perform prostatectomy with his resectoscope but he fails to remove completely all prostatic tissue or, in fact, all hypertrophic tissue in the process of performing this operation and this cannot be denied; in fact, circumstances occasionally arise that necessitate his terminating an operation before he has performed what he honestly believes to be a complete operation although he knows full well that his patient will be able to urinate satisfactorily when the catheter is removed. Certainly any type of prostatectomy that fails to remove all prostatic tissue will inevitably be followed in some instances by a recurrence of hypertrophy and a recurrence of obstruction. There is no type of prostatectomy short of total perineal removal of the gland and its capsule that gives prophylaxis against recurrence.

"When enucleation is performed, either by suprapubic or the perineal route, there will no doubt be a lesser incidence of recurrent hypertrophy and obstruction than that which follows the less complete removal of the gland by even the most meticulous, skillful and completely performed resection, and the incidence of recurrent obstruction with the resectoscope will, to a large measure, depend upon the experience and skill of the operator. In its final analysis I think that the inherent disadvantages of occasional or rare recurrent obstruction that follows transurethral resection must be balanced against the patient's evaluation of this operation in comparison with open prostatectomy. I dare say I have performed between fifty and seventy-five transurethral resection operations upon patients with recurrent obstruction following previous resection in patients who had enjoyed a satisfactory result following the first operation. In none of these cases did the patient object when operation was advised for the relief of recurrent obstruction. During the same period of time I have had the opportunity to see at least a dozen patients with recurrent obstruction following open prostatectomy. It has interested me a great deal to question the latter group regarding their attitude toward another operation. None of them would submit to another open operation willingly if any other possible means for relief of their obstruction were available. In practically every instance the patients in this group have voluntarily asked whether they could not have the newer operation performed. These patients, like the ones who have recurrent obstruction following transurethral resection, are not at all unwilling to submit to the resection procedure for they are very much aware of the advantages that the transurethral has to offer the patient insofar as comfort, and length of hospital stay are concerned.

"I once was privileged to take care of a retired professor who lived in Ann Arbor. This man had hypertrophy of the prostate with obstruction requiring prostatectomy. I relieved his obstruction by performing transurethral resection upon him and the operation that I performed on this patient was the third that he had experienced for the relief of prostatism. His first prostatectomy was performed by the hand of Dr. Hugh Young in Baltimore. Twenty years later Dr. Hugh Cahot performed a suprapubic prostatectomy on this patient and the operation I performed on him succeeded

the Cabot operation by twelve years. I removed 38 grams of tissue with the resectoscope. This man was kind enough to say after his convalescence had been completed that if he had to have another prostatectomy he would certainly insist upon having it done with the resectoscope."

Dr. Ruben Flocks, of Alcock's Clinic, Iowa City, Iowa, writes:

"We have done approximately 10,000 resections on 7,000 or 8,000 patients. We are more and more pleased with our results, and more and more sold on the operation."

Dr. Alfred I. Folsom of Dallas, Texas says:

"Our experience has been indicative of the fact that the permanence of a well done resection or probably I had better say the permanence of a transurethral prostatectomy seems to me to be equal if not superior to that of suprapubic prostatectomy or perineal prostatectomy. However, I think our time phase has been too short to evaluate this part of this very interesting problem properly. I certainly feel that there should be a clear cut line drawn between the individuals who are doing simply a channeling operation or a revision of the prostate and those who are now for the last few years doing prostatectomies with the resectoscope, going down to the capsule; for I feel that whereas in the first group there will be a large number of recurrences and the permanence of it will not be ideal, yet in this latter group I think that the permanence of it will be as good if not better than the suprapubic or perineal prostatectomy."

We ourselves have done approximately 3,000 prostatic resections. In our early work a rather high percentage were poorly and inadequately done. Many patients required more than one resection. As experience and skill were acquired, we have been, during the past five or six years, removing by far the greater portion of the hypertrophic prostate and, naturally, all the obstructing tissue. Our results have been more satisfactory as this has been done.

The experience of these men, from whose letters we have quoted, who have done a total of more than 30,000 transurethral resections so closely parallels our own experience that we can but agree with the one main thought that has been brought out; that is, complete removal of obstructing and hypertrophic prostatic tissue affords lasting, permanent, and highly satisfactory results.

804-810 Healey Building.

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Industrial X-ray programs are likely to play a major role in tuberculosis control during the next decade.—Editorial, *Am. Jour. P. H.*, Nov., 1945.

## FORTY YEARS OF MEDICINE

*The Science; the Art; Organization  
in Georgia*

JOHN W. SIMMONS, M.D.  
Brunswick

*I once had a store  
Of knowledge and lore.  
Under an old high hat.  
But, the older I grow  
The less I know.  
And I'm not so sure of that.*

—J. W. S.

This humble contribution, a familiar story to those of us who have marvelled at the pace of medical progress through the past forty years, including as it does the quickened research attending two world wars, will perhaps remind the hosts of the younger members that they are heirs of long lines of toilers who have made their tasks in diagnosis and treatment easier, and spur them on to the same effort to more spectacular advances during their generation.

I have vainly promised to make this paper a little different from the thousands of such that from time-to-time have reviewed the progress of medicine, but so rapid are the advances it is quite a difficult task to keep up with them, much less take time out for retrospective reviews, so a terse chronologic record of the highlights only is attempted, remembering that this recording represents more spectacular inventions and discoveries than in the previous four hundred years, perhaps, prior to the discovery of the germ causation of many diseases.

Here begins the brief chronologic anthology:

- 1905—*Spirocheta pallida* discovered by Schaudinn.
- 1906—Wassermann reaction.
- 1907—Sugar from protein in diabetes, by Lusk.
- 1908—Einhorn's introduction of duodenal tube and bucket.
- 1909—Discovery of salvarsan by Ehrlich.
- 1910—Use of digitalis in fibrillation by MacKenzie.
- 1911—Beri beri vitamin isolated by Funk.
- 1912—Calculation of blood reaction from  $\text{CO}_2$  by Henderson, Hasselbach and Lundsgaard.
- 1913—Test of immunity to diphtheria by Schick.
- 1914—Classification of arrhythmias, and their possible origins, by Enkebach.
- 1915—Studies on spirochetoses icterohemorrhagica, by Inada.
- 1916—Bronchoscopic advances, by Chevalier Jackson.
- 1917—Introduction of the gas burette by VanSlyke, making the tests for amino-nitrogen, carbon and alkali reserve in the blood, for urea, for organic acids in urine, and other important tests so much easier and simpler.
- 1918—Introduction of quinidine, by Frey.
- 1919—Advances in colloid chemistry, by Loeb.
- 1920—Study of  $\text{CO}_2$  and intracellular reaction, by Jacobs.
- 1921—Insulin, as saviour of diabetics, by Banting and co-workers.
- 1922—Lipiodol, with lipiodology, by Sicard. From this came the then marvelous roentgenographic technics in diagnosis.
- 1923—Application of colloid chemistry (see 1917) to mammalian blood, by VanSlyke, Wu and McLean. This is the precursor of present-day intravascular shock therapy.
- 1924—Scarlatinal antitoxin introduced by Dochez and the Dicks.
- 1925—Cholecystography, by Graham's use of tetraiodophenolphthalein and its salts.
- 1926—Parathyroid extract introduced by Collip.
- 1927—Minot, Murphy and Cohn developed liver extracts, isolating their various factors, in the treatment of pernicious and primary anemias. (My personal thanks to these men).  
Irradiated ergosterol (vitamin D), and the irradiated milk (by ultraviolet) in prevention of rickets.
- 1928—Pituitary hormones isolated from gland by Cann. (Price then three million dollars a pound).
- 1929—Vitamin B, previously regarded as a single substance, shown to have two or three constituent vitamins. (And still the constituents increase, with requirements for several yet unknown).  
Theelin isolated from urine of pregnant women, by Doisy, Veler and Thayer.
- 1930—Progress in eradication of cattle tick in quarantined areas of 983 southern counties.  
Discovery and isolation of carotin (Vitamin A).  
Development of hormone from adrenal cortex, used in treatment of Addison's disease in same manner as insulin for diabetes.  
Artificial lung developed by Drinker and Shaw.
- 1931—Fleas found to be carriers of typhus fever.  
Two new anesthetics, one a barbiturate, the other a gas for inhalation.
- 1932—Discovery, alleged, of mode of infection in infantile paralysis by Simon Flexner.
- 1933—Research in pituitary gland physiology marked in this year. Formaldehydesulfoxylate, first known antidote for bichloride of mercury poisoning, announced by Dr. S. H. Rosenthal. U. S. P. H. S.  
First surgical removal of an entire lung on an adult patient.  
Smallpox vaccine from virus grown on hen's eggs, instead of from calf, first used.
- 1934—Cortin, life-saving hormone of adrenal gland cortex, obtained in pure crystalline form, with



chemical formula, discovered by Dr. E. C. Kennedy, Mayo Foundation.

Discovery that amidopyrine and chemically related headache and pain-relieving remedies, were one, if not sole, cause of agranulocytopenia—fatal bone marrow disease—reported by Drs. Madison and Squire, Milwaukee. This research was also aided, and possibly established, by Drs. Roy R. Kracke and Francis P. Parker, of Emory University.

Relief of several cases of hitherto hopeless Pick's disease (lipoid hystiocytosis) by removal of part of pericardium, reported by Drs. Paul D. White and E. D. Churchill, Massachusetts General Hospital.

Synthetic production of male sex hormones reported by Dr. L. Ruzicka, Zurich, Switzerland. (Too near Berchtesgaden).

Protamine insulinate, called the "most valuable discovery in the treatment of diabetes since the original discovery of insulin," developed.

"Apparently successful" use of a preparation known as prontosil. Sulfanilamide in the treatment of beta hemolytic streptococcus infections, including scarlet fever, puerperal fever and erysipelas, was reported by Drs. Perrin H. Long and Eleanor A. Bliss, Johns Hopkins Medical School, and in England by Dr. Leonard Colebrook, Medical Research Council, and Dr. Meave Kennedy and associates, Queen Charlotte's Hospital, London. The chemical was first prepared and used in Germany four years ago (1931). Here we hail the first of the sulfonamides under a proprietary name. Ten years old in America!

1936—Successful use of placental extract in treatment of hemophilia, by Eley and McKhann.

1937—Culture of Rocky Mountain spotted fever germs for first time on artificial media.

Discovery of new Vitamin P, related to Vitamin C.

1938—Vitamin K isolated in crystalline form and given with bile salts to decrease bleeding in obstructive jaundice. Now used for bleeding from other causes.

Anti-sterility vitamin E synthesized as alpha tocopherol, and used in habitual abortion in humans and lower animals. It is interesting to note that we have now a much more effective preventive in the follicular hormone.

Value of nicotinic acid in pellagra established.

Serum for treating type III pneumonia became available.

1939—Metrazol shock therapy found effective in many cases of dementia praecox or schizophrenia. Now the electricians have taken over.

1940—A serum was developed for treating Rocky Mountain fever.

Successful vein grafting and splicing was done with the aid of heparin, which is now used also in prevention of thromboses and embolisms.

Four hundred permanent cures from 401 operations done for the relief of Meniere's disease. One death, which was also permanent.

1941—First trials on human patients of the precursor of

the penicillins—gramacidin. Effective in numbers of infections in body cavities and viscera as well as wounds.

Identification and typing of viruses accomplished by collodion fixation method for more rapid diagnosis of virus diseases.

1942—"For the first time in medical history disease fighting substances in the blood, known as antibodies," and which had been measured and studied for years, "were formed artificially in laboratory flasks, confirming the theory of molecular changes in immunization."

Discovery of certain needs in humans for certain amino acids in protein foods. For instance, arginine for spermatogenesis (hope for the azoospermics?); lysine in the female reproductive cycle; tryptophan in baldness, sex gland atrophy in males, teeth defects and cataracts in growing animals. Gentlemen, please don't crowd!

1943—"Continuous caudal analgesia" came to the fore as a rainbow of hope in promised relief from the curse of pain in childbirth which was placed upon Eve and her daughters for an indiscretion with a snake instead of a wolf. This also is used for operative procedures and for relief of war wounded.

"The St. Louis and Japanese B types of encephalitis were successfully prevented in half of those vaccinated, according to blood tests for susceptibility."

A second, more potent weapon, penatin, was found in the same mold which yielded penicillin. Large scale production of penicillin, the development of other strains, the use of fermentation as well as surface culture methods, in production to meet universal demands.

Discovery of a "fear-and-worry" chemical in the blood, as yet unidentified, but believed responsible for physical changes resulting from emotional upsets, was announced. (There are probably many of us who would welcome the dropping of its incognito and permit identification).

1944—Some vague reports regarding the effectiveness of penicillin from some strains of Indian molds related to penicillium nodosum, etc., as I recall, were published, and detailed effectiveness in some common colds and other virus infections possibly sensitive to the specific strain, and gave rays of hope.

Enough of chronology in the science of medicine. Consult today's literature. Now, in order to maintain my reputation for prolixity, if not for my devious processes of ratiocination, it might not be amiss to outline some of the advances in organized medicine in Georgia during the past forty years.

The Medical Association of Georgia was founded, as you know, in 1849; but was completely reorganized in its set-up just forty years ago — 1905. Prior to that lat-



ter date membership was not divided into county societies. There were no district societies as we know them now. Membership from the state-at-large was purely voluntary and individually sought by making application, being vouched for by two reputable practitioners and being approved by the board of censors, was granted. In 1905 the door for admission became the county society, as a component part of the state body, and upon which the State Association depends wholly for its existence.

During these forty years we have seen the Medical Association of Georgia grow from a membership of approximately 600 to its present membership of 2,006 regular and active, associate, intern and honorary classifications. All have been proud to have had a small part in building its constitution and by-laws, which are not yet perfect. We rejoice in seeing its individual members and the organization as a whole keep pace with every effort to improve the health and prolong the lives of every Georgian. We have done this by increasing and extending its standing committees and special advisory committees to cover every factor in Georgia's advancing program as it relates to matters of health and hygiene.

Two programs I have suggested have not met with much attention, but I am hoping their expediency and necessity in the light of national trends will pave the way for some consideration.

These are, first, the participation of the Association as a whole, through every member in active practice, in a statewide prepayment medical service plan, directed and managed on a fee basis, within a non-profit corporation subsidiary to our own.

The second recommendation is the organization of security for our aged and ill members through a group prepayment plan connected with our state dues. There will always be some who have given their all and have not been able to accumulate enough to make enforced retirement secure. Let's take care of them.

The green cloth-bound volumes of the Transactions of our Association, published annually up to the launching of our JOURNAL, are treasured volumes in my library, for in them I find the rich gold of Georgia

doctors' contributions to medical literature, much of it entirely original research and experience. I find listed illustrious names, honored by sacred memories.

Men, we are still making medical history in Georgia since the founding of the first Georgia Medical Society in Savannah over 141 years ago. At Augusta members of the faculty of the University of Georgia School of Medicine have introduced to the world numbers of products of their research and inventive genius. At Emory University research is now bold, daring and commendable. I am told that at the latter place some unparalleled research is now in progress, the results of which seem well nigh incredible.

We are on the thresholds of still more spectacular inventions and discoveries in diagnosis and treatment. While we revere the science, let us hold high the art and ethics of the profession. May we pray for minds agile enough, for cerebration quickened to the tempo of an all too rapidly advancing world; for high expectations in keeping pace in a mutual spirit of helpfulness. May we pray for faith and forbearance that will make for fellowship in the high ideals of our service.

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Author's note: Some quotations have been made in their entirety. Most of yearly discoveries have been briefed like events in Grier's Almanac, for instance. It was a labor of love to present this brief anthology—which means the "gathering of the most beautiful flowers" along medicine's pathway.

#### THE FAMILY PHYSICIAN AND TUBERCULOSIS

The average patient has a great deal of confidence in his private physician and expects him to treat tuberculosis much as he would accept other family medical emergencies. Psychological factors make this desirable and practical considerations make it feasible, especially if the physician possesses sufficient broad understanding of tuberculosis and modern therapeutic methods. Sanatorium care is no longer the only method of tuberculosis control. Many minimal lesions and a limited number of inactive advanced lesions are amenable to out-patient supervision under strict medical care. This supervision and care can often be rendered by the alert general practitioner who possesses modern knowledge of the diagnosis and treatment of tuberculosis.—Herman E. Hilleboe, M.D., U. S. Public Health Service.

# THE PRESIDENT'S PAGE

## OUR ANNUAL MEETING

The program for the annual meeting of the Medical Association of Georgia is printed in this number of *THE JOURNAL*, and this will be our first meeting in two years.

It was a great disappointment and every one of us suffered deprivation not to have had the annual meeting of the Medical Association of Georgia last year. Somehow the summer didn't start right. Because of the exigencies of war, conventions were prohibited, and your officers have had to hold over and serve a second term. Everything had to be sacrificed to finishing off the war. So it is with unusual pleasure that we anticipate the meeting in Macon, May 7-10.

We want the privilege of welcoming back home the many doctors who have been away in the armed services for several years. We have missed them, and what a pleasure it will be to have them back again. They have done a great job, for which we owe them all our thanks and gratitude. The scientific program, the scientific exhibits, and the technical displays are of much more than the usual interest and excellence. These and, best of all, Macon's hospitality urge every doctor in Georgia to come together in this post-war meeting.

It is particularly important that the delegates to this session be present at all the meetings of the House of Delegates and *attend* to their business. Of equal importance is the session on the last day at noon for the election of officers. Every bona fide member should be present and exercise his privilege and responsibility to vote his wishes. This is a new day in the Medical Association of Georgia, and we should look well to keeping the Association fully organized for the high purposes for which it was founded.

Again, we would like to see every doctor in Georgia at the 1946 meeting of the Association. Let's make it the best session in its history.

CLEVELAND THOMPSON, M.D.

# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

March, 1946

## JOURNAL URGES LEGISLATORS TO STUDY A. M. A. HEALTH PLAN

### *Locally Administered Prepayment Medical Plans Long Step Toward Protecting People Against Cost of Sickness*

The revised national health program of the American Medical Association "may well suggest to legislators in the Senate and in the House the point of view of the medical profession as to the part that the federal government can play in extending necessary medical services to those who do not now have them," according to an editorial in the February 23 issue of *The Journal of the American Medical Association*.

The editorial follows in full:

At the annual session of the American Medical Association in Chicago in December the House of Delegates adopted a resolution instructing "the Board of Trustees and the Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis on the nationwide organization of locally administered prepayment medical plans sponsored by medical societies."

At a series of meetings held in Chicago beginning February 13 the Board of Trustees and the Council on Medical Service completed considerations which made possible a long step toward protecting the American people against the costs of sickness.

The fundamental step in the development of this plan was the establishment of standards of acceptance for medical care plans which have the approval of the Council on Medical Service of the American Medical Association. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material. In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician. The plans must be organized and operated to provide the greatest possible benefits in medical

care to the subscriber.

Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the cost incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities and periodic checking and reporting of the progress of the plan to the Council.

Coincidentally with the announcement of these standards of acceptance there was organized, as a voluntary federation, an organization known as Associated Medical Care Plans, Inc. This independent association will include as members all plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The Associated Medical Care Plans will undertake to establish coordination and reciprocity among all of these plans to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located. Under this method great industrial organizations with plants in various portions of the United States will be able to secure coverage for all their employees. Moreover, it will be possible for the Veterans Administration, welfare and industrial groups and government agencies to provide coverage for the people in any given area through a system of national enrolment. In addition the Associated Medical Care Plans, Inc., will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans and engage in a great campaign of public education as to the medical service plan movement under the auspices of state and county medical societies.

The Board of Trustees of the American Medical Association also announced establishment of a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities related to the promotion and development of medical care plans in all the states.

In announcing these proposals for a nationwide provision of sickness insurance on a mutual nonprofit basis, the Board also presented a complete health program with ten points, which include the development of services in the field of preventive medicine, maternal and child health, voluntary prepayment plans for protection against the costs of sickness, compensation for loss of wages due to illness, the care of the veteran and the development of a high standard of housing, nutrition, clothing and recreation.

The American Medical Association last June through its Board of Trustees and Council on Medical Service announced a fourteen point program to improve the health and medical care situation in the United States. In October 1945 the interpretation of these fourteen points and



methods of implementation were adopted by the Council on Medical Service. In December 1945 the House of Delegates approved the whole program, suggested its rearrangement and directed the Board of Trustees to keep the program constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

With this in mind the Board of Trustees has adopted a restatement of the fourteen point program, which clarifies still further the position of the American Medical Association on some of these points and brings into the program more definitely maternal and child welfare, medical research, the medical care of the veteran and the part to be played by the voluntary health agencies.

This restatement follows:

*National Health Program of  
The American Medical Association*

1. The American Medical Association urges a minimum standard of nutrition, housing, clothing and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function, since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care, including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice, with funds provided by local agencies with the assistance of federal funds when necessary.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price they can afford to pay. When local funds are lacking for the care of those unable to pay, federal aid should be supplied with the funds administered through local or state agencies.

4. The child should have throughout infancy

proper attention, including scientific nutrition, immunization against preventable disease and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

5. The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established (Hill-Burton bill).

6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice, with payment by the Veterans Administration through a plan mutually agreed on between the state medical association and the Veterans Administration.

8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending federal legislation, is endorsed.

9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enter-

prise and democracy that prevail in the United States. Their participation in a national health program should be encouraged, and the growth of such agencies when properly administered should be commended.

10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations and school authorities.

During the coming weeks the Council on Medical Service will announce the activities that will be followed toward promoting the prepayment medical care plan and also the standards of acceptance that have been developed for such plans. The Division of Prepayment Medical Care Plans in the headquarters office will soon be active in aiding the development of plans in areas which do not now have them and in coordinating existing plans.

The policies of the Association as expressed in the National Health Program may well suggest to legislators in the Senate and in the House the point of view of the medical profession as to the part that the federal government can play in extending necessary medical services to those who do not have them.

#### HOSPITALS

There have been many requests for information about the construction of hospitals addressed to the State Department of Public Health since the passage of the Hill-Burton Bill (S. 191) by the U. S. Senate. This is the bill which provides an appropriation of five million dollars for surveying the present hospital facilities and the need for more hospital beds, and of seventy-five million dollars annually for five years for erecting new hospitals or enlarging existing ones.

From the number of letters and inquiries that come to the State Department of Public Health, it appears that every county, and almost every town and village, in Georgia wants to plan for a hospital. This is a wholesome sign, as all will agree that a hospital should be within comparatively easy reach of every person, and that a hospital bed should be available to every person who needs one.

It is well known that the number of hospital beds in Georgia is far below the minimum need of three beds per thousand population, and that the present location of those available leaves many people practically out of reach of them. As a general thing, the absence of hospital facilities also means the absence of physicians and medical care.

Conversely, if a hospital is available to every section, physicians and medical care will also

be available, provided, of course, that the hospitals are strategically located and properly equipped, and are of the proper size and construction.

It is obvious that every town and community, or every county in Georgia, cannot support a general hospital. Careful planning as to location and size of these hospitals is very essential, and the physicians of Georgia are manifestly the ones to guide in this matter.

Although the Hill-Burton Bill may be further amended and changed in the House of Representatives, it may be supposed that it will remain practically as it is, and that its present provisions may be used as a guide in planning for future hospital expansion.

The first provision is for an inventory of existing hospitals and a survey of the need for construction of additional hospitals or enlargement of present public or non-profit hospitals as will *in conjunction with present facilities* afford adequate hospital, clinic and similar services to all the people. Note that existent hospital facilities are not to be discontinued. This inventory and survey are getting under way in Georgia, and the cooperation and assistance of all hospitals and physicians are requested.

The bill provides that a single state agency be appointed to carry out the purposes of the bill, and that an advisory council be appointed, including representatives of non-governmental and state agencies concerned with the operation, construction or utilization of hospitals, to consult with the designated state agency. At the 1945 session, the General Assembly of Georgia designated the State Board of Health as this agency in Georgia and provided for the advisory council. This council has been appointed and has met with the State Board of Health several times already.

Within six months after the passage of the Hill-Burton Bill, the Surgeon General of the United States Public Health Service, in conjunction with the Federal Hospital Council, shall formulate regulations as to the number of beds for general hospitals; for tuberculosis, mental and chronic diseases; and for health centers; and the general method or methods by which these beds shall be distributed, and the manner in which the state agency shall determine the priority of projects. It is specified that special consideration be given to hospitals serving rural communities and sections with limited financial resources.

The Surgeon General of the Public Health Service shall also fix general standards of construction and equipment for hospitals. These standards will vary as to class and location of the hospital.

#### STATE PLANS

In order for a state to be eligible to receive its quota of funds, it must conform to the fol-



lowing, in addition to the specifications cited above:

A plan for a construction program based upon existing hospitals and the need for other hospitals in conformance with the Federal regulations must be submitted to the Surgeon General of the Public Health Service for approval by him and the Federal Hospital Council.

There must be no discrimination because of race, color or creed, or in furnishing needed hospital services to persons unable to pay.

Assurance must be given that financial resources for maintenance and operation of the hospitals are available.

Plans must include provision for administration under a merit system of personnel standards. However, the Surgeon General of the Public Health Service shall have no authority with regard to the selection, tenure of office, or compensation of any person employed by such a hospital.

Each state, to be eligible to participate in these funds, must provide minimum standards for the maintenance and operation of hospitals, and must enact legislation to provide for these minimum standards not later than July 1, 1947, or forfeit its right to any further allotments under the bill.

Funds allotted to any state for a fiscal year and not utilized during that year, will be available to the state for the next fiscal year and no longer.

The recent session of the General Assembly enacted a law which provides that the State Board of Health, after consulting with a hospital advisory committee, shall fix minimum standards for hospitals and similar institutions. This advisory committee shall consist of three members appointed by the Georgia Hospital Association, five by the Medical Association of Georgia, one by the Georgia Nursing Association, one by the Georgia Dental Association, and five lay members appointed by the Governor, and the Director of the State Department of Public Health, the Director of Public Welfare, the Attorney General, and the State Auditor. This committee will be appointed at an early date.

#### APPROVAL OF PROJECTS

Each application for funds under this bill shall set forth the following:

1. Applicant is a public or non-profit agency.
2. Description of the site.
3. Plans and specifications.
4. Reasonable assurance the title is or will be vested in the applicant.
5. Reasonable assurance that adequate financial support will be available for the construction, maintenance and operation of the project.
6. Assurance that laborers and mechanics engaged in the construction will not be paid less than the prevailing wage rates for similar work.
7. Assurance that the facilities will not be

denied anyone because of race, color, creed, or inability to pay for services.

The Hill-Burton Bill also provides that the Federal Government may recover a percentage of the value of any such hospital if such hospital, within twenty years after completion, ceases to be non-profit, or is sold or transferred to any person not qualified to file an application.

As nearly as possible at this time, Georgia has met the provisions of this bill, and anticipates being prepared to benefit from the funds at once when they are available.

The State Advisory Council for advising with the State Board of Health in determining the priority of projects based on the relative needs of different sections has been appointed. A law providing for fixing minimum standards for the maintenance and operation of hospitals by the State Board of Health after conferring with a Hospital Advisory Committee has been enacted. This committee will be appointed at an early date, after which such standards will be promulgated.

The State plan will be submitted to the Surgeon General of the Public Health Service very soon after the Federal plan is announced.

Only the highlights of this important bill can be given in this article. Copies of the Hill-Burton Bill (S. 191) can be obtained from your Senator or Representative, or by writing the State Department of Public Health. We shall be glad to send copies of the Georgia Hospital Law.

GUY G. LUNSFORD, M.D.

*Deputy Director,*

Georgia Department of Public Health

#### WELCOME TO MACON

It has always been with pleasure that the Bibb County Medical Society has been host to the Medical Association of Georgia. This year a greater meeting than ever is anticipated.

Since the conflict is over and most of the doctors in the service have returned home, a record-breaking attendance is expected. Plans are being made to take care of all in attendance but since the hotel situation has not eased up much we suggest that hotel reservations be made at once. Elsewhere in THE JOURNAL a list of hotels will be found.

We believe that every doctor attending the convention will profit thereby, and the Bibb County Medical Society assures every one that every effort possible will be made to make your visit to Macon a genuine pleasure.

#### BIBB COUNTY MEDICAL SOCIETY

W. W. BAXLEY, *President,*

A. M. PHILLIPS, *Secretary.*

#### MACON'S CONVENTION HOTELS

Hotel Dempsey

Central Hotel

Georgian Hotel

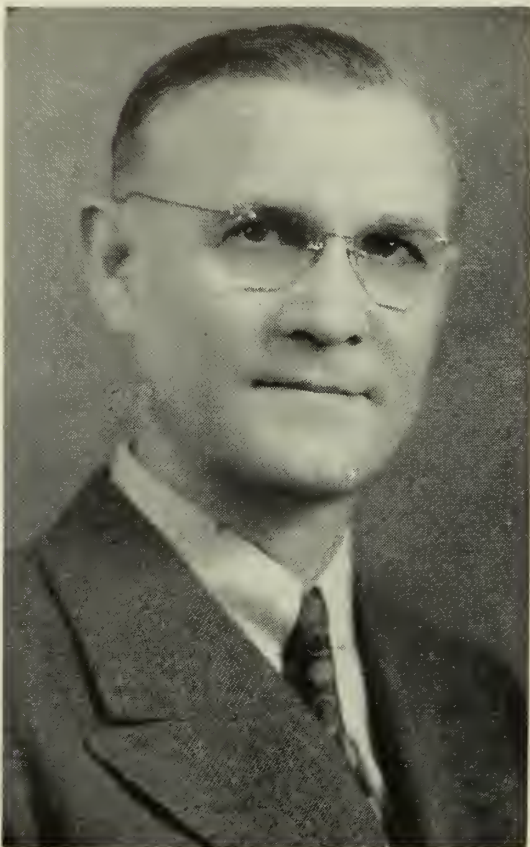
Hotel Lanier

Southland Hotel

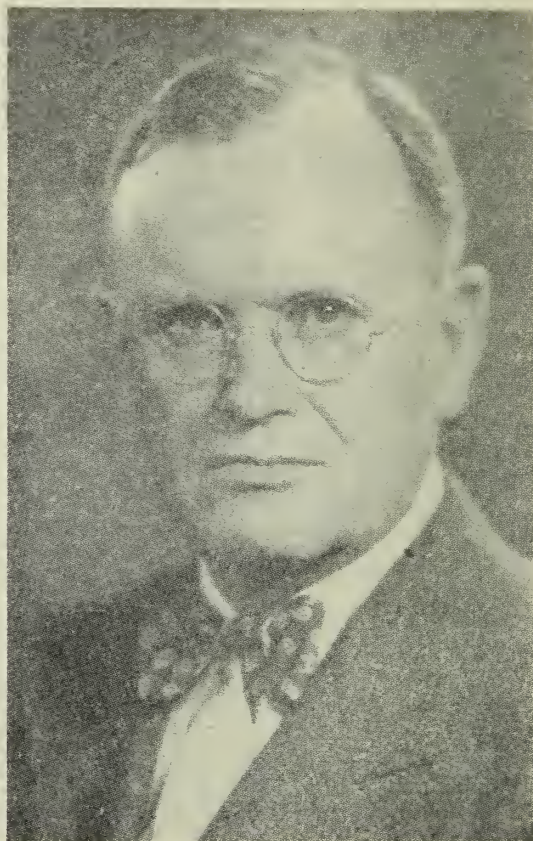
Milner Hotel



## OFFICERS OF THE MEDICAL ASSOCIATION OF GEORGIA



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President, 1944-46



**RALPH HILL CHANEY, M.D.**  
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**Ruskin King, M.D.**  
Savannah  
First Vice-President



**J. B. Kay, M.D.**  
Byron  
Second Vice-President



**Edgar Shanks, M.D., Atlanta**  
Secretary-Treasurer and  
Editor of The Journal



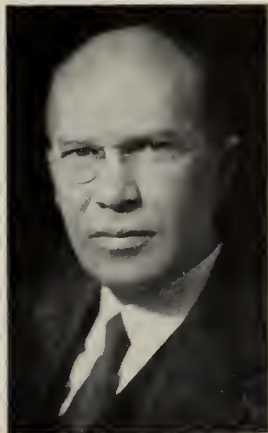
**John W. Simmons, M.D.**  
Brunswick, Parliamentarian

The officers of the Medical Association of Georgia urge its members to attend the Ninety-Sixth Annual Session to be held at the City Auditorium, Macon, May 7-10, 1946.

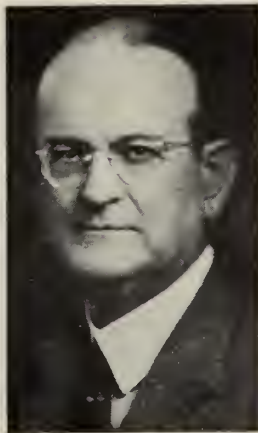
The House of Delegates will convene Tuesday, May 7, at 2:00 P.M. at the City Auditorium. The scientific session will open May 8 at 8:30 A.M.



Wm. A. Mulherin, M.D.  
Augusta  
Delegate to the A.M.A.  
(Deceased)



Allen H. Bunce, M.D.  
Atlanta  
Delegate to the A.M.A.



Olin H. Weaver, M.D.  
Macon  
Delegate to the A.M.A.



Benj. H. Minchew, M.D.  
Waycross  
Alternate Delegate to the A.M.A.



H. Clifford Sauls, M.D.  
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C. K. Sharp, M.D.  
Arlington  
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Councilor, First District



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Thomasville  
Councilor, Second District



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Dawson  
Councilor, Third District



Kenneth S. Hunt, M.D.  
Griffin  
Councilor, Fourth District



Marion C. Pruitt, M.D.  
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Councilor, Fifth District



H. D. Allen, Jr., M.D.  
Milledgeville  
Councilor, Sixth District





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Marietta  
Councilor, Seventh District



Wm. F. Reavis, M.D.  
Waycross  
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C. B. Lord, M.D.  
Jefferson  
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H. L. Cheves, M.D.  
Union Point  
Councilor, Tenth District



Chas. T. Brown, M.D.  
Guyton  
Vice-Councilor, First District



Chas. H. Watt, M.D.  
Thomasville  
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Columbus  
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Enoch Callaway, M.D.  
LaGrange  
Vice-Councilor, Fourth District



Spencer A. Kirkland, M.D.  
Atlanta  
Vice-Councilor, Fifth District



H. G. Weaver, M.D.  
Macon  
Vice-Councilor, Sixth District



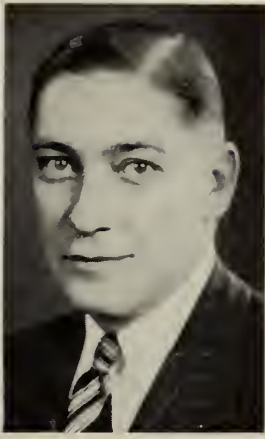
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Vice-Councilor, Seventh District



Alton M. Johnson, M.D.  
Vadosta  
Vice-Councilor, Eighth District



D. H. Garrison, M.D.  
Clarkesville  
Vice-Councilor, Ninth District



J. Victor Roule, M.D.  
Augusta  
Vice-Councilor, Tenth District



Viola Berry  
Atlanta  
Executive Secretary

#### MEDICAL ASSOCIATION OF GEORGIA

*Ninety-Sixth Annual Session*

MACON

MAY 7, 8, 9, 10, 1946

OFFICERS AND COMMITTEES, 1944-1945<sup>1</sup>

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President-Elect ..... Ralph H. Chaney, Augusta  
First Vice-President ..... Ruskin King, Savannah  
Second Vice-President ..... J. B. Kay, Byron  
Parliamentarian ..... Jno. W. Simmons, Brunswick  
Secretary-Treasurer ..... Edgar D. Shanks, Atlanta

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Allen H. Bunce (1945-46) ..... Atlanta  
Alternate, H. C. Sauls ..... Atlanta  
Olin H. Weaver (1944-45) ..... Macon  
Alternate, C. K. Sharp ..... Arlington

1. The Office of Defense Transportation, Washington, D. C., denied the Association's request to hold the annual session in 1945, therefore all officers and committees were continued until another annual session could be held.
2. Deceased.

##### *Council*

Steve P. Kenyon, Chairman ..... Dawson  
Marion C. Pruitt, Clerk ..... Atlanta

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2. C. K. Wall (1945) ..... Thomasville  
3. Steve P. Kenyon (1945) ..... Dawson  
4. Kenneth S. Hunt (1945) ..... Griffin  
5. Marion C. Pruitt (1946) ..... Atlanta  
6. H. D. Allen, Jr. (1946) ..... Milledgeville  
7. W. H. Perkinson (1946) ..... Marietta  
8. W. F. Reavis (1946) ..... Waycross  
9. C. B. Lord (1947) ..... Jefferson  
10. Harry L. Cheves (1947) ..... Union Point

##### *Vice Councilors*

1. Chas. T. Brown (1945) ..... Guyton  
2. C. H. Watt (1945) ..... Thomasville  
3. Guy J. Dillard (1945) ..... Columbus  
4. Enoch Callaway (1945) ..... LaGrange  
5. S. A. Kirkland (1946) ..... Atlanta  
6. H. G. Weaver (1946) ..... Macon  
7. D. Lloyd Wood (1946) ..... Dalton  
8. Alton M. Johnson (1946) ..... Valdosta  
9. D. H. Garrison (1947) ..... Clarkesville  
10. J. Victor Roule (1947) ..... Augusta

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Steve P. Kenyon, Chairman, Council ..... Dawson  
Edgar D. Shanks, Secretary-Treasurer ..... Atlanta

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*of the*

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N. R. Thomas ..... Albany

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J. J. Clark	Atlanta
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L. P. Pierce	Waycross
Hartwell Joiner	Gainesville
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Alabama: D. S. Reese, Carrollton; Mercer Blanchard, Columbus; R. F. Wheat, Bainbridge.  
 Florida: Wm. W. Anderson, Atlanta; Grady N. Coker, Canton; Hal M. Davison, Atlanta.  
 North Carolina: Allen H. Bunce, Atlanta; Ralph M. Goss, Athens. (Deceased).  
 South Carolina: G. Lombard Kelly, Augusta; Stewart

D. Brown, Royston; J. M. Byne, Jr., Waynesboro.  
 Tennessee: J. T. McCall, Rome; Trammell Starr, Dalton.

*State Board of Health\**

First District: James M. Byne, Jr., Waynesboro, Sept. 1, 1945.  
 Second District: C. K. Sharp, Arlington, Sept. 1, 1945.  
 Third District: J. C. Patterson, Cuthbert, Sept. 1, 1948.  
 Fourth District: J. A. Corry, Barnesville, Sept. 1, 1949.  
 Fifth District: Mr. Robert F. Maddox, Sept. 1, 1948.  
 Sixth District: C. L. Ridley, Macon, Sept. 1, 1944.  
 Seventh District: W. P. Harbin, Jr., Rome, Sept. 1, 1944.  
 Eighth District: B. H. Minchew, Waycross, Sept. 1, 1944.  
 Ninth District: Robert L. Rogers, Gainesville, Sept. 1, 1945.  
 Tenth District: D. N. Thompson, Elberton, Sept. 1, 1948.

## STATE OF GEORGIA AT LARGE†

*Georgia Dental Association*

W. K. White, Savannah, Sept. 1, 1945.  
 J. G. Williams, Atlanta, Sept. 1, 1945.

*Georgia Pharmaceutical Association*

George Wright, Tifton, Sept. 1, 1947.  
 John W. White, Thomasville, Sept. 1, 1947.

\*Nominated by their respective district medical societies and appointed for six year terms.

†Nominated by their respective associations.

## STATE BOARD OF MEDICAL EXAMINERS

L. G. Neal.....	Cleveland
J. I. Matthews.....	Dallas
R. F. Wheat.....	Bainbridge
Murdock Equen.....	Atlanta
Steve P. Kenyon.....	Dawson
Harold P. McDonald.....	Atlanta
J. W. Palmer.....	Ailey
T. H. Clark.....	Douglas
Rufus A. Askew.....	Atlanta
Grady N. Coker.....	Canton

## DISTRICT SOCIETIES

## OFFICERS AND MEETING DATES

*First District*

President—J. M. Byne, Jr., Waynesboro  
 Secretary—Wm. D. Wilson, Savannah  
 Third Wednesdays—March and July

*Second District*

President—Helen W. Bellhouse, Thomasville  
 Secretary—J. C. Brim, Pelham  
 Second Thursdays—April and October

*Third District*

President—Willis P. Jordan, Columbus  
 Secretary—W. G. Elliott, Cuthbert  
 Third Wednesday in June—Second Wednesday in November

*Fourth District*

President—T. J. Busey, Fayetteville  
 Secretary—M. M. Head, Zebulon  
 Second Wednesdays—February and August

*Fifth District*

President—Homer H. Allen, Decatur  
 Secretary—George A. Williams, Atlanta  
 No set dates

*Sixth District*

President—J. A. Fountain, Macon  
 Secretary—A. M. Phillips, Macon  
 Last Wednesday in June—First Wednesday in December

*Seventh District*

President—Fred H. Simonton, Chickamauga  
 Secretary—Inman Smith, Rome  
 First Wednesday in April—last Wednesday in September

*Eighth District*

President—J. R. Gray, Waycross  
 Secretary—G. T. Crozier, Valdosta  
 Second Tuesdays—April and October

*Ninth District*

President—E. F. Chaffin, Toccoa  
 Secretary—Pratt Cheek, Gainesville  
 Dates not specified

*Tenth District*

President—D. N. Thompson, Elberton  
 Secretary—W. D. Gholston, Danielsville  
 Second Wednesdays—February and August

## DELEGATES TO THE 1946 SESSION

COUNTIES	NAMES AND ADDRESSES
Appling	
Baldwin	C. G. Cox, Milledgeville
Banks	
Bartow	H. B. Bradford, Cartersville
Ben Hill	W. D. Willcox, Fitzgerald
Bibb	W. W. Baxley, Macon
	J. B. Kay, Byron
Blue Ridge	
Brooks	Harry A. Wasden, Quitman
Bulloch-Candler-Evans	A. B. Daniel, Claxton
Burke	J. M. Byne, Jr., Waynesboro
Carroll	S. F. Scales, Carrollton
Chatham—	
Georgia Medical Society	J. L. Elliott, Savannah
	G. L. Touchton, Savannah
Chattooga	J. S. Williamson, Trion
Cherokee-Pickens	
Clarke-Madison-Oconee	Sam M. Talmadge, Athens
Clayton-Fayette	Y. R. Coleman, Jonesboro
Cobb	E. S. Davis, Acworth
Coffee	Sage Harper, Ambrose
Colquitt	J. B. Woodall, Moultrie
Coweta	
Crisp	P. L. Williams, Cordele
Decatur-Seminole	R. F. Wheat, Bainbridge
DeKalb	
Dooly	
Dougherty	H. M. McKemie, Albany
Douglas	C. V. Vansant, Douglasville
Elbert	D. N. Thompson, Elberton
Emanuel	D. D. Smith, Swainsboro
Floyd	J. T. McCall, Sr., Rome
Forsyth	Marcus Mashburn, Sr., Cumming
Franklin	E. T. Pool, Lavonia
Fulton	L. Minor Blackford, Atlanta
	A. O. Linch, Atlanta
	Lester A. Brown, Atlanta

Joseph C. Massee, Atlanta	
C. W. Strickler, Jr., Atlanta	
Hugh Hailey, Atlanta	
Mark S. Dougherty, Atlanta	
W. A. Selman, Atlanta	
I. G. Towson, Sea Island	
Glynn	
Gordon	
Grady	J. V. Rogers, Cairo
Greene	Franklin H. Killam, Greensboro
Gwinnett	W. W. Puett, Norcross
Habersham	D. H. Garrison, Clarkesville
Hall	C. D. Welchel, Gainesville
Hancock	C. S. Jernigan, Sparta
Haralson	C. H. Allen, Bremen
Hart	
Henry	H. C. Ellis, McDonough
Houston-Peach	
Jackson-Barrow	
Jasper	F. S. Belcher, Monticello
Jefferson	
Jenkins	Katherine Rawls, Sylvania
Lamar	
Laurens	R. G. Ferrell, Jr., Dublin
Macon	Thomas M. Adams, Montezuma
McDuffie	
Meriwether	R. B. Gilbert, Greenville
Mitchell	J. C. Brim, Pelham
Monroe	
Montgomery	J. W. Palmer, Ailey
Morgan	
Muscogee	
Newton	
Ocmulgee: Bleckley-Dodge-Pulaski	
Polk	O. R. Styles, Cedartown
Rabun	
Randolph-Terrell	W. G. Elliott, Cuthbert
Richmond	R. C. McGahee, Augusta
Rockdale	H. E. Griggs, Conyers
Screven	
South Georgia Medical Society: Berrien-Clinch-Cook-	
Echols-Lanier-Lowndes	E. F. Thompson, Valdosta
Spalding	T. G. Smaha, Griffin
Stephens	
Sumter	R. C. Pendergrass, Americus
Tattnall	L. V. Strickland, Cobbtown
Taylor	Lewis Beason, Butler
Telfair	S. T. Parkerson, McRae
Thomas	
Tift	W. H. Hendricks, Tifton
Toombs	
Tri-County Society: Calhoun-Early-	
Miller	J. G. Standifer, Blakely
Tri-County Society: Liberty-Long-McIntosh	
Troup	
Turner	
Upson	R. L. Carter, Thomaston
Walker-Cotoosa-Dade	Fred H. Simonton, Chickamauga
Walton	Charles S. Floyd, Loganville
Ware	W. F. Reavis, Waycross
Warren	A. W. Davis, Warrenton
Washington	E. G. Newsome, Sandersville
Wayne	J. A. Leaphart, Jesup



Whitfield.....Truman Whitfield, Dalton  
 Wilcox.....  
 Wilkes.....H. L. Cheves, Union Point  
 Worth.....

### ANNOUNCEMENTS

Meetings will be held in the City Auditorium.

Be sure to go to the Registration Desk immediately after your arrival, present your 1946 membership card, register and procure a badge and program.

Discussion of papers is open to all members and guests of the Association; it is not limited to those named on the program.

On arising to discuss a paper the speaker will please announce his name and address clearly for the benefit of the Association and the reporter.

Meetings will be called to order at the hour fixed on the program. It is especially desired that the members be prompt in their attendance.

All manuscript should be typewritten, double spaced, and on one side of the paper only. Papers must be handed to the Reporter immediately after being read.

### IMPORTANT NOTICE

Delegates must present written credentials to the Committee on Credentials from the House of Delegates to secure delegates' badges.

Members may not take part in the proceedings until they have registered and procured official badges.

### PUBLIC MEETINGS

*Eastern Standard Time*  
 City Auditorium, Macon

WEDNESDAY, MAY 8, 8:30 A.M.  
 Opening Meeting

WEDNESDAY, MAY 8, 8:00 P.M.

Presentation of the President's Gold Key to President Cleveland Thompson, Millen, by Edgar R. Pund, Augusta.

THURSDAY, MAY 9, 12:00 NOON  
 President's Address  
*The Doctor in This New Day*  
 Cleveland Thompson, Millen

The President's Address will be at an open session to which the public and visitors are invited.

### MEMORIAL EXERCISES

A. J. Mooney, Statesboro  
 Chairman, Committee on Necrology

### ENTERTAINMENTS

WEDNESDAY, MAY 8, 1:00 P.M.  
 Hotel Dempsey

Annual luncheon of the Georgia Eye, Ear, Nose and Throat Society.

WEDNESDAY, MAY 8, 1:30 P.M.

Luncheon of the American Medical Women's Association. "The Columns," 367 College Street.

WEDNESDAY, MAY 8, 6:30 P.M.

Hotel Dempsey

Annual dinner of the alumni of Emory University School of Medicine. W. A. Newman, Chairman.

Annual dinner of the alumni of University of Georgia School of Medicine. H. G. Weaver, Chairman.

THURSDAY, MAY 9, 12:30 P.M.

Hotel Dempsey

Annual Luncheon of the Georgia Pediatric Society.

Meeting of the Fellows of the American Academy of Pediatrics will follow immediately.

THURSDAY, MAY 9, 1:30 P.M.

Hotel Dempsey

Annual luncheon of the Georgia Roentgenological Society.

THURSDAY, MAY 9, 7:30 P.M.

Annual banquet of the Medical Association of Georgia.  
 Dance

### MEETINGS OF THE HOUSE OF DELEGATES

City Auditorium, Macon

TUESDAY, MAY 7, 2:00 P.M.  
*Eastern Standard Time*

First meeting of the House of Delegates

1. Call to order by the President
2. Roll Call
3. Appointment of Reference Committees
4. Reports of officers:

President  
 President-Elect  
 Vice-Presidents  
 Parliamentarian  
 Secretary-Treasurer: Financial report  
 Reports of Delegates to the A.M.A.

5. Reports of committees:

Scientific Work  
 Public Policy and Legislation  
 Arrangements  
 Medical Defense  
 Hospitals  
 Necrology  
 Cancer Commission  
 History  
 Abner Wellborn Calhoun Lectureship  
 Awards  
 Advisory—State Board of Health  
 Advisory—Woman's Auxiliary  
 Medical Economics  
 Orthopedics—Advisory, State Department of Public Welfare  
 Ophthalmology—Advisory, State Department of Public Welfare  
 Syphilis  
 Tuberculosis  
 Special Committees

6. Unfinished business
7. New business

TUESDAY, MAY 7, 8:00 P.M.

*Eastern Standard Time*  
 City Auditorium, Macon

Second Meeting of the House of Delegates

1. Call to order by the President
2. Reading of minutes

3. Announcements
4. Report of President of Woman's Auxiliary
5. Reports of committees continued
6. Reports of Fraternal Delegates
7. Unfinished business
8. New business

FRIDAY, MAY 10, 8:00 A.M.  
*Eastern Standard Time*  
 Hotel Dempsey, Macon

Third Meeting of the House of Delegates

1. Call to order by the President
2. Reading of minutes
3. Reports of committees
4. Unfinished business
5. New business

#### OFFICIAL REPORTER

Miss Winifred H. McLean ..... Gastonia, N. C.

#### MEETINGS OF THE COUNCIL

TUESDAY, MAY 7, 5:00 P.M.  
*Eastern Standard Time*  
 City Auditorium, Macon

The first meeting of the Council will be held in the City Auditorium, Tuesday, May 7, following the afternoon session of the House of Delegates. Each Councilor will render a report of conditions of each county of his district. Other meetings of the Council will be held on the call of the chairman.

#### SCIENTIFIC PROGRAM

WEDNESDAY, MAY 8, 8:30 A. M.  
*Eastern Standard Time*  
 Macon City Auditorium

The papers for each meeting *must* be read as scheduled on the program.

Call to order by the President, Cleveland Thompson, Millen.

#### Invocation

Albert S. Trulock, Macon.  
 Pastor, Vineville Methodist Church.

#### Address of Welcome

Charles H. Richardson, Sr., Macon.

#### Response to Address of Welcome

W. F. Reavis, Waycross.

#### SCIENTIFIC PROGRAM

*The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.*

1. The Etiology of Convulsions.  
 Homer S. Swanson, Atlanta.
2. The Treatment of Epilepsy in Children With Sodium Dilantin.  
 Benjamin Bashinski, Macon.
3. Observations of Electroencephalic Patterns in Convulsive Disorders of Suspected Endocrine Origin (Preliminary report).  
 Estelle P. Boynton, Atlanta.  
 To lead the discussion of papers 1, 2 and 3:  
 Wm. A. Smith, Atlanta.  
 Hervey Cleckley, Augusta.

4. Congenital Heart Disease—Discussion of Some of the More Common Types (With lantern slides).  
 Laura Lipscomb, Atlanta.
5. The Practical Diagnosis of Congenital Heart Lesions Amenable to Treatment.  
 Harry T. Harper, Jr., Augusta.  
 Marion W. Mathews, Augusta.  
 To lead the discussion of papers 4 and 5:  
 H. C. Atkinson, Macon.  
 L. Minor Blackford, Atlanta.

6. Report of Several Interesting Allergic Cases.  
 Eugenia C. Jones, Atlanta.  
 Mason I. Lowance, Atlanta.  
 Warren B. Matthews, Atlanta.

To lead the discussion:

W. W. Chrisman, Macon.  
 J. A. Redfearn, Albany.

7. An Effective Contraceptive: Phenyl Mercuric Acetate Jelly.  
 Amey Chappell, Atlanta.
8. The Treatment of Bartholin Abscess.  
 Edgar H. Greene, Atlanta.  
 To lead the discussion of papers 7 and 8:  
 John T. Persall, Jr., Augusta.  
 H. F. Sharpley, Jr., Savannah.

9. A Report on the Progress of Public Health in Georgia.

T. F. Abercrombie, Atlanta.

To lead the discussion:

W. P. Harbin, Rome.  
 Pratt Cheek, Gainesville.

WEDNESDAY, MAY 8, 12:00 NOON  
*Eastern Standard Time*  
 Macon City Auditorium

#### ABNER WELLBORN CALHOUN LECTURE *The Early Diagnosis of Neurosurgical Conditions*

Winchell M. Craig  
 Mayo Clinic,  
 Rochester, Minn.

Introduction by James E. Paullin, Atlanta.

WEDNESDAY, MAY 8, 2:00 P. M.  
*Eastern Standard Time*  
 Macon City Auditorium

*The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.*

1. One Year's Experience With The Mobile X-Ray Unit.  
 Abe Davis, Augusta.  
 E. S. Sanderson, Augusta.  
 To lead the discussion:  
 O. E. Ham, Savannah.  
 J. R. Evans, Decatur.
2. Paratyphoid B Meningitis in An Infant: Report of Case.  
 Leonard R. Massengale, Augusta.  
 To lead the discussion:  
 A. M. Johnson, Valdosta.  
 Hall Farmer, Macon.
3. The Surgical Management of the Obstructive Prostate.  
 Glenn J. Bridges, Atlanta.



To lead the discussion:

Wallace Bazemore, Macon.

W. P. Jordan, Columbus.

4. Symposium on Respiratory Problems:

a. Advancement in the Treatment of Common Infections in the Lungs.

A. Worthy Hobby, Atlanta.

b. Some Non-specific Factors Inducing Asthma, and Their Treatment.

John L. Jacobs, Atlanta.

c. Tuberculosis in Private Practice.

Carl C. Aven, Atlanta.

d. The Social Prophylactic Medical and Surgical Aspects of Bronchiectasis.

Osler A. Abbott, Atlanta.

e. Superior Sulcus Pulmonary Tumor (Pancoast syndrome).

John E. Walker, Columbus.

f. Magnetic Removal of Foreign Bodies From the Air and Food Passages.

Murdock Equen, Atlanta.

To lead the discussion:

Robert Major, Augusta.

H. E. Crow, Alto.

D. R. Venable, Columbus

S. C. Lynn, Savannah.

C. B. Fulghum, Milledgeville.

WEDNESDAY, MAY 8, 8:00 P. M.

*Eastern Standard Time*

Macon City Auditorium

Presentation of the President's Gold Key to the President, Cleveland Thompson, Millen, by Edgar R. Pund, Augusta.

*Correcting Some of Nature's Mistakes by Surgical Intervention.*

Oswald Swinney Lowsley, New York, N. Y.

Introduction by Rudolph Bell, Thomasville.

*Our Battle for Freedom.*

Harrison H. Shoulders, Nashville, Tenn.

President-Elect, American Medical Association.

Introduction by C. W. Roberts, Atlanta.

*Psychosomatic Gynecology.*

J. P. Pratt, Detroit, Mich.

Introduction by B. H. Minchew, Waycross.

*Tropical Diseases in the African Negro.*

(Motion pictures in color)

M. Fernan-Nunez, Milledgeville.

THURSDAY, MAY 9, 8:30 A. M.

*Eastern Standard Time*

Macon City Auditorium

*The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.*

1. Complications of Antirabic Treatment.

T. F. Sellers, Atlanta.

To lead the discussion:

Benjamin Bashinski, Macon.

A. J. Waring, Savannah.

2. Hyperparathyroidism, A Fairly Common But Unrecognized Metabolic Disorder.

Christopher J. McLoughlin, Atlanta.

To lead the discussion:

J. C. Metts, Savannah.

E. F. Wahl, Thomasville.

3. Experiences With Malaria on a Pacific Island.

C. Dixon Fowler, Atlanta.

To lead the discussion:

V. P. Sydenstricker, Augusta.

M. E. Winchester, Brunswick.

4. The Blood Sedimentation Test As An Aid in Diagnosis.

C. Purcell Roberts, Atlanta.

5. Anti-Rh Factors in Blood Typing.

A. J. Ayers, Atlanta.

6. Rh Factor in Relation to Diseases of the Infant.

R. C. McGahee, Augusta.

To lead the discussion of papers 4, 5 and 6:

Francis Parker, Atlanta.

Lee Howard, Savannah.

7. A Digression on Sexual Hair—Contrasting Cushing's Syndrome With Sexual Infantilism.

Robert B. Greenblatt, Augusta.

To lead the discussion:

J. K. Fancher, Atlanta.

H. D. Allen, Jr., Milledgeville.

8. The Recognition and Management of Early Psychosomatic Disorders.

R. S. Leadingham, Atlanta.

To lead the discussion:

Thomas Ross, Macon.

James N. Brawner, Jr., Smyrna.

9. The Outlook for the University of Georgia School of Medicine.

G. Lombard Kelly, Augusta.

To lead the discussion:

E. A. Stead, Atlanta.

Grady Coker, Canton.

THURSDAY, MAY 9, 12:00 NOON

*Eastern Standard Time*

Macon City Auditorium

PRESIDENT'S ADDRESS

*The Doctor in This New Day.*

Cleveland Thompson, Millen

*Memorial Exercises*

A. J. Mooney, Statesboro,

Chairman, Committee on Necrology

THURSDAY, MAY 9, 2:00 P. M.

*Eastern Standard Time*

Macon City Auditorium

*The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.*

1. Newer Concepts of the Growth of the Placenta.

Joseph Krafka, Jr., Augusta.

2. Further Observations on the Two-Hour Pregnancy Test.

- Herbert Kupperman, Augusta.
3. Inversion of the Uterus.  
Richard Torpin, Augusta.
  4. The Production and Relief of Dysmenorrhea Symptoms in Humans.  
R. A. Woodbury, Augusta.  
Richard Torpin, Augusta.  
George C. Child, Augusta.  
Marie Jarboe, Augusta.  
To lead the discussion of papers 1, 2, 3 and 4:  
Schley Gatewood, Americus.  
C. B. Upshaw, Atlanta.
  5. Diphtheria Antitoxin and Other Foreign Protein in the Treatment of Herpes Zoster Ophthalmicus: Report of Eight Cases.  
Wes C. Thomas, Brunswick.  
To lead the discussion:  
B. H. Minchew, Waycross.  
Henry Moore, Thomasville.
  6. Importance of Early Diagnosis of Tumors of the Bladder.  
Harold P. McDonald, Atlanta.  
Alexander J. Filip, Atlanta.  
To lead the discussion:  
S. Elliott Wilson, Savannah.  
W. F. Lake, Atlanta.
  7. Reactions Due to Topical Application of Sulfonamides.  
Wm. L. Dobes, Atlanta.
  8. Tropical Skin Diseases Among Naval Personnel in the South Pacific (Lantern slides).  
Herbert S. Alden, Atlanta.
  9. Sporotrichosis: Report of Case.  
D. H. Garrison, Clarkesville.
- To lead the discussion of papers 7, 8 and 9:  
Hugh Hailey, Atlanta.  
Max Mass, Macon.  
Cosby Swanson, Atlanta.  
Shelton Sanford, Savannah.

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FRIDAY, MAY 10, 9:00 A. M.

*Eastern Standard Time*

Macon City Auditorium

*The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.*

1. Symposium on Surgical Problems:
  - a. Surgery on Elderly Patients.  
W. W. Baxley, Macon.
  - b. Peptic Ulcer: Review of the Present-Day Treatment.  
Robert F. Norton, Rome.
  - c. Surgery of the Colon in Wartime.  
D. Henry Poer, Atlanta.
  - d. Surgical Management of Ileocolitis.  
Lon Grove, Atlanta.
  - e. The Use of Thiouracil in the Treatment of Toxic Goiter, and its Dangers.  
T. C. Davison, Atlanta.
  - f. The Present Status of Pilonidal Cysts.  
Marion C. Pruitt, Atlanta.
  - g. Subphrenic Abscess: Case Reports.  
John W. Turner, Atlanta.

- h. Spinal Anesthesia.  
J. M. Kellum, Thomaston.
  - i. Further Consideration of the Malignant Lymphoma.  
John Funke, Atlanta.
  - j. Topical Application of Thrombin and Plasma in Split Skin Grafts.  
Chas. E. Rushin, Atlanta.
- To lead the discussion:  
O. H. Weaver, Macon.  
Ben H. Clifton, Atlanta.  
C. F. Holton, Savannah.  
J. C. Patterson, Cuthbert.  
John H. Sherman, Augusta.  
W. E. Person, Atlanta.  
Richard Binion, Milledgeville.

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#### ELECTION OF OFFICERS

FRIDAY, MAY 10, 12:00 NOON

*Eastern Standard Time*

City Auditorium, Macon

- President-Elect  
First Vice-President  
Second Vice-President  
Parliamentarian  
Secretary-Treasurer  
Three delegates to the A. M. A.  
Three alternate delegates to the A. M. A.  
\*Councilors for the First to Eighth Districts, inclusive  
\*Members of the State Board of Health  
Selection of meeting place for 1947  
\*Nominated by their respective districts.

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#### • CONSTITUTION AND BY-LAWS

Chapter II. Section 2. No papers or addresses before the Association, except those of the President and invited essayists, shall occupy more than fifteen minutes in their delivery; and no member shall speak longer than five minutes, nor more than once on any subject, provided that each essayist shall have five minutes in which to close the discussion of his paper.

Chapter VIII. Section 1. The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Chapter VIII. Section 2. All papers read before the Association shall become its property. Each paper shall be deposited with the Secretary when read, and if this is not done it shall not be published.

No miscellaneous or business matters will be discussed before the scientific meetings, but will be referred to the House of Delegates.

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#### *Resolution Adopted 1921*

Resolved: That a member who sends in a title of a paper to be placed on the program and is not present to read the paper shall pay the penalty of not having an opportunity to appear on the program for two years, unless he presents an excuse acceptable to the Committee on Scientific Work.

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We are instructed by the President to announce to all essayists that the sessions of the Scientific Program of the Association will begin on time, and that the above

regulations of the By-Laws in reference to the program will be strictly enforced.

#### COMMITTEE OF SCIENTIFIC WORK

B. H. Minchew, Waycross, Chairman

Ralph H. Chaney, Augusta

Edward J. Whelan, Savannah

Edgar D. Shanks, Atlanta, Secretary-Treasurer

#### EXHIBITS

##### CITY AUDITORIUM

##### *Macon*

May 7-10, 1946

1. Miaco Hearing Service  
Peachtree Arcade Building, Atlanta, Ga.
2. Holland-Rantos Company, Inc.  
551 Fifth Avenue, New York, N. Y.
3. Frederick Stearns & Company  
Detroit 31, Mich.
4. Otis E. Glidden & Company  
518 Davis Street, Evanston, Ill.
5. Walker Vitamin Products, Inc.  
Mount Vernon, N. Y.
6. The Harrower Laboratory, Inc.  
Glendale, Calif.
7. U. S. Vitamin Corporation  
250 East 43rd St., New York 17, N. Y.
8. The Maltine Company  
745 Fifth Ave., New York 22, N. Y.
9. The Southeastern Optical Company  
3rd Floor Rhodes Building, Atlanta, Ga.
10. Estes Surgical Supply Company  
56 Auburn Ave., N.E., Atlanta, Ga.
11. Ortho Pharmaceutical Corporation  
Linden, N. J.
- 11-A. Doak Company, Inc.  
2132 East 9th St., Cleveland, O.
12. Van Pelt & Brown, Inc.  
Richmond, Va.
- 12-A. The Mennen Company  
Newark, N. J.
13. Eli Lilly and Company  
Indianapolis, Ind.
14. The C. V. Mosby Company  
3207 Washington Blvd., St. Louis 3, Mo.
15. Sharp & Dohme, Inc.  
Philadelphia 1, Pa.
- 15-A. G. D. Searle & Company  
Chicago 80, Ill.
16. Ciba Pharmaceutical Products, Inc.  
LaFayette Park, Summit, N. J.
17. The Borden Company  
350 Madison Ave., New York 17, N. Y.
18. Mead Johnson & Company  
Evansville, Ind.
19. C. B. Fleet Company, Inc.  
821-927 Commerce St., Lynchburg, Va.
20. The Meta Cine Company  
546 McCallie Ave., Chattanooga, Tenn.  
Ben Perryman, P. O. Box 242, Atlanta, Ga.
- 21-22. American Surgical Supply Company  
489 Peachtree St., N.E., Atlanta 3, Ga.
- 22-A. Lederle Laboratories, Inc.  
30 Rockefeller Plaza, New York 20, N. Y.

23. Burroughs-Wellcome Company, Inc.  
9-11 East 41st St., New York 17, N. Y.
24. Surgical Selling Company  
139 Forrest Ave., N.E., Atlanta, Ga.
- 24-A. M & R Dietetic Laboratories, Inc.  
Columbus, O.
25. Schering Corporation  
Bloomfield, N. J.
- 25-A. Doho Chemical Company  
58 Varick St., New York 13, N. Y.
26. Pet Milk Sales Corporation  
Arcade Building, St. Louis 1, Mo.
27. A. S. Aloe Company  
1831 Olive St., St. Louis, Mo.  
W. W. Clary, Box 207, Vienna, Ga.
28. A. J. Majors Company  
1301 Tulane Ave., New Orleans 13, La.
29. E. R. Squibb & Sons  
745 Fifth Ave., New York, N. Y.
- 29-A. L. & B. Reiner  
139 East 23rd St., New York 10, N. Y.
30. Ayerst, McKenna & Harrison, Ltd.  
22 East 40th St., New York 16, N. Y.
- 30-A.-31-A. Everhart Surgical Supply Company  
499 Peachtree St., N.E., Atlanta, Ga.
31. White Laboratories, Inc.  
Newark 2, N. J.
32. Polaris Company, Inc.  
12 High Street, Jersey City, N. J.
33. Philip Morris & Co., Ltd., Inc.  
119 Fifth Avenue, New York, N. Y.
34. Parke, Davis & Company, Inc.  
Detroit 32, Mich.
35. The Wm. S. Merrell Company  
Cincinnati, O.
36. Winthrop Chemical Co., Inc.  
New York 13, N. Y.

#### IN MEMORIAM

- Adams, Charles M., Atlanta, July 3, 1945, age 74.
- Ainsworth, Harry, Thomasville, June 19, 1945, aged 68.
- Allen, George Ollie, Marietta, May 26, 1945, aged 73.
- Ansley, Hamilton Goss, Decatur, December 16, 1945, aged 43.
- Aycock, Thomas Rufus, Monroe, Augusta 5, 1944, aged 62.
- Ballenger, Edgar Garrison, Atlanta, June 1, 1945, aged 68.
- Banks, John, Hamilton, May 16, 1944, aged 66.
- Barnett, Stephen Trent, Atlanta, June 27, 1944, aged 73.
- Barron, Carey A., Kingsland, April 24, 1944, aged 57.
- Barrow, Craig, Savannah, August 31, 1945, aged 69.
- Birdsong, Henry Walter, Athens, October 10, 1944, aged 61.
- Borders, William Andrew, Armuchee, January 15, 1945, aged 78.
- Brannen, Clifford, Atlanta, March 7, 1946, aged 56.
- Brice, Joseph Theobald, Cumming, October 2, 1944, aged 78.
- Brinson, Homer Hodges, Brinson, August 25, 1944, aged 66.



- Brown, Jackson Frank, Macon, August 16, 1943, aged 51.  
 Bruce, Francis Marion, Homerville, December 22, 1945, aged 63.  
 Bullard, Thomas Parker, Palmetto, January 19, 1945, aged 74.  
 Burkhalter, John F., Claxton, May 6, 1945, aged 59.  
 Burns, McIntosh Marcus, Pelham, March 10, 1946, aged 53.  
 Burpee, Claude McKinley, Augusta, December 2, 1944, aged 47.  
 Campbell, Jesse Hope, Commerce, April 14, 1945, aged 55.  
 Carothers, James Bell, Atlanta, January 17, 1945, aged 56.  
 Carson, H. D., Union Point, March 23, 1945, aged 73.  
 Carson, Marcus F., Griffin, November 26, 1944, aged 73.  
 Chandler, Julian H., Swainsboro, August 20, 1945, aged 66.  
 Christian, John E., Duluth, November 11, 1945, aged 78.  
 Cleckley, Marsden Trentlen, Augusta, May 8, 1944, aged 73.  
 Collins, Norman V., Griffin, November 24, 1944, aged 55.  
 Colvard, Thomas Winfrey, Crandall, September 17, 1945, aged 76.  
 Crawford, Claud Burton, Blue Ridge, November 6, 1944, aged 71.  
 Curry, Joel Toy, Macon, June 30, 1945, aged 74.  
 Daniel, Byron, Sardis, November 16, 1945, aged 70.  
 Darden, Holt, Blakely, January 30, 1946, aged 47.  
 Davis, John Weyman, Athens, September 18, 1944, aged 42.  
 Downey, Carroll William, Tallapoosa, April 8, 1945, aged 69.  
 Duckett, Alfred Kennon, Blue Ridge, August 18, 1944, aged 33.  
 Eberhardt, Benjamin Franklin, Gillsville, February 21, 1944, aged 75.  
 Elder, Omar F., Atlanta, October 25, 1944, aged 58.  
 Eubanks, George Foster, Atlanta, September 25, 1944, aged 44.  
 Fuqua, Elmer F., Atlanta, January 6, 1945, aged 65.  
 Garland, John Thomas, Macon, February 18, 1945, aged 88.  
 Gibson, Obe C., Macon, April 23, 1945, aged 83.  
 Goodwyn, Henry J., Carrollton, June 24, 1944, aged 70.  
 Goss, Ralph Montgomery, Athens, March 12, 1946, aged 67.  
 Gostin, Bernard Singleton, Macon, August 28, 1945, aged 65.  
 Guffin, Thomas Frederick, East Point, November 22, 1944, aged 69.  
 Harbin, Foster Pierce, Lumber City, June 15, 1944, aged 56.  
 Harrell, Sandy Byars, Macon, August 23, 1945, aged 77.  
 Hembree, James I., Atlanta, July 5, 1944, aged 54.  
 Hesse, Herman William, Savannah, November 24, 1944, aged 68.  
 Hilsman, Agnew Hodge, Albany, August 23, 1945, aged 69.  
 Hinton, John Willis, Atlanta, April 10, 1944, aged 74.  
 Hinton, William T., Dacula, May 17, 1945, aged 76.  
 Hoke, Michael, Atlanta, September 23, 1944, aged 70.  
 Holden, Alexander Stephens, Ellijay, April 16, 1944, aged 78.  
 Holliday, James Carlton, Athens, March 11, 1946, aged 60.  
 Hooten, John M., Woodbury, September 12, 1944, aged 83.  
 Hubert, Terrell Eugene, Milledgeville, September 21, 1945, aged 78.  
 Huey, Horace Gordon, Homerville, August 25, 1945, aged 54.  
 Humber, Jesse Weathers, Lumpkin, January 15, 1946, aged 56.  
 Johnson, Cleon Denton, Columbus, October 3, 1944, aged 50.  
 Johnson, Daniel Nohle, Decatur, October 18, 1944, aged 93.  
 Johnson, Melville T., Atlanta, February 15, 1946, aged 78.  
 Johnston, J. J., LaFayette, December 17, 1945, aged 79.  
 Kelley, Charlie A., Lilburn, March 18, 1944, aged 72.  
 Kennedy, John Payson, Atlanta, September 17, 1944, aged 80.  
 Kennedy, Wallace D., Metter, December 28, 1945, aged 73.  
 King, George Wiley, Atlanta, January 12, 1946, aged 74.  
 Kinney, James R., Fort Valley, May 9, 1945, aged 82.  
 Liggins, Samuel B., Montezuma, October 2, 1944, aged 68.  
 Loveless, Jackson Cleveland, Grayson, August 4, 1945, aged 55.  
 Malone, Will Hale, Atlanta, July 10, 1944, aged 54.  
 Maloy, James Williamson, Rhine, September 1, 1945, aged 60.  
 Mashburn, Charles Marcellus, Atlanta, August 14, 1945, aged 55.  
 Mathews, James Hortmon, Rehecca, March 27, 1945, aged 59.  
 Mathews, William Lester, Winder, May 4, 1945, aged 58.  
 McAliley, Robert George, Atlanta, September 15, 1945, aged 66.  
 McCarthy, Daniel Joseph, Savannah, February 22, 1945, aged 37.  
 McCurdy, William Tarlton, Stone Mountain, February 13, 1946, aged 70.  
 McKenzie, Robert Douglas, Albany, October 27, 1944, aged 34.  
 Meeks, William Thomas, Blairsville, July 10, 1944, aged 70.  
 Middleton, Charles Seahorn, Blakely, February 13, 1946, aged 74.  
 Mitchell, Julius Shuford, Rome, December 2, 1945, aged 72.  
 Mulherin, William Anthony, Augusta, April 19, 1945, aged 72.  
 Nall, James Daniel, Atlanta, January 24, 1946, aged 64.  
 Noble, George Henry, Atlanta, February 12, 1946, aged 56.  
 O'Neal, Rance, West Point, September 11, 1944, aged 70.  
 Osborne, Lyman Sanderson, Fitzgerald, August 6, 1945, aged 90.  
 Palmer, Joseph Barnes, Thomasville, November 3, 1944, aged 67.  
 Payne, James W., Monticello, October 30, 1945, aged 56.  
 Petway, Thomas Franklin, Atlanta, May 22, 1944, aged 66.  
 Pirkle, William Homer, Cochran, July 25, 1944, aged

Power, Iron Clifton, Hiram, November 15, 1945, aged 69.  
 Reid, Charles Washington, Pelham, January 1, 1946, aged 78.  
 Revell, Samuel T. R., Louisville, January 13, 1945, aged 65.  
 Rhyne, William H. F., LaFayette, December 1, 1944, aged 81.  
 Robinson, Walter C., Atlanta, June 17, 1944, aged 88.  
 Rose, John Rudolph, Sale City, aged 88.  
 Sanford, Eugene Farmer, Buchanan, August 2, 1945, aged 55.  
 Savage, James Henry, Atlanta, February 8, 1945, aged 62.  
 Schwalb, Otto W., Savannah, April 17, 1945, aged 43.  
 Scruggs, Samuel Andrew, Americus, February 26, 1944, aged 54.  
 Sears, William D., Ellaville, March 14, 1945, aged 68.  
 Sessions, Walter Wesley, Sumner, May 21, 1945, aged 70.  
 Shallenberger, William Farquhar, Atlanta, December 16, 1944, aged 63.  
 Shellhorse, Evan Otis, Dalton, November 19, 1945, aged 67.  
 Short, Bland P., Newton, February 29, 1944, aged 77.  
 Smith, Benjamin L., Forsyth, July 7, 1945, aged 63.  
 Smith, Charles Sherman, Clarkesville, February 11, 1946, aged 82.  
 Smith, Marvin R., Cordele, July 12, 1943, aged 66.  
 Smith, William Thomas, Tifton, December 8, 1945, aged 69.  
 Spearman, Walter Dudley, Social Circle, April 30, 1945, aged 69.  
 Stephens, Charles Manfred, Waycross, aged 63.  
 Stephens, Lee D., Sycamore, February 12, 1945, aged 63.  
 Stewart, Thomas Hill, Jr., Eastman, January 6, 1944, aged 51.  
 Swain, William H., Martin, May 20, 1945, aged 76.  
 Swanson, Benjamin G., Jr., Atlanta, March 17, 1945, aged 62.  
 Swint, Roger C., Atlanta, August 8, 1945, aged 70.  
 Thomason, John Washington, East Point, December 19, 1945, aged 65.  
 Timmerman, John Patterson, Hephzibah, February 25, 1944, aged 69.  
 Tipton, Walter Charles, Sylvester, December 12, 1944, aged 62.  
 Tolhurst, George Monroe, Atlanta, June 27, 1944, aged 69.  
 Turk, John Pierce, Nelson, October 26, 1944, aged 65.  
 Walker, Robert Carroll, Waycross, January 9, 1943, aged 54.  
 Walkonig, Christian, Atlanta, April 13, 1945, aged 67.  
 Ware, Robert Mayhue, Fitzgerald, October 23, 1945, aged 62.  
 Wells, James R., Stone Mountain, January 1, 1945, aged 72.  
 Wiggins, Lee Wilbert, Atlanta, July 20, 1944, aged 68.  
 Williamson, Johnathan Wooden, Atlanta, April 27, 1943, aged 29.  
 Woods, James Edgar, Atlanta, February 3, 1945, aged 77.  
 Young, William Walter, Atlanta, September 7, 1945, aged 55.

## CONSTITUTION AND BY-LAWS OF THE MEDICAL ASSOCIATION OF GEORGIA

### Constitution

#### ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Medical Association of Georgia.

#### ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purpose of this Association shall be to federate and bring into one component organization the entire medical profession of the State of Georgia; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of state and medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

#### ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county societies which hold charters from this Association.

#### ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1. This Association shall consist of members and delegates.

Sec. 2. Members: The members of this Association shall be the members of the component county medical societies to which only white physicians shall be eligible.

Sec. 3. Delegates: Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

#### ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Association, and shall consist of: (1) delegates elected by the component county societies; (2) the officers of the Association enumerated in Section 1 of Article IX of the Constitution; (3) ex-presidents and delegates to the American Medical Association.

#### ARTICLE VI.—COUNCIL

The Council shall be the Board of Trustees and Finance Committee of the Association. The Council shall have full authority and power of the House of Delegates between annual sessions, unless the House of Delegates be called into session as provided in the Constitution and By-Laws.

It shall consist of the Councilors, the President, the President-Elect and the Secretary-Treasurer of the Association. Five of its members shall constitute a quorum.

#### ARTICLE VII.—SESSIONS AND MEETINGS

Section 1. The annual session shall take place on the second Wednesday in May at such place as shall be designated by the Association, provided that in case of conflict with the annual session of the American Medical Association or on petition of the county society of the host city made at least six months before the fixed dates for the annual session, the Council may change the dates

by publishing a notice in the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA three months before the session.

Sec. 2. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, or upon the petition of twenty delegates.

#### ARTICLE VIII.—SECTIONS AND DISTRICT SOCIETIES

Section 1. The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections, and for the organization of such Councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

#### ARTICLE IX.—OFFICERS

Section 1. The officers of this Association shall be a President, President-Elect, two Vice-Presidents, a Secretary-Treasurer, a Parliamentarian, and one Councilor for each congressional district in the State.

Sec. 2. The officers, except the Secretary-Treasurer, Parliamentarian and Councilors, shall be elected annually, provided that after the annual meeting of 1928 a President-Elect and not a President shall be elected annually. The President-Elect shall assume his office as President immediately after the next annual meeting following his election. The terms of the Councilors shall be for three years, as may be arranged, viz: the Councilor for the first, second, third and fourth districts for three years; those for the fifth, sixth, seventh, and eighth districts for one year; those for the ninth and tenth districts for two years. The Secretary-Treasurer shall be elected for a term of five years, and the Parliamentarian for a term of three years. All these officers shall serve until their successors are elected and installed (1933).

Sec. 3. The officers of this Association shall be elected by ballot at 12 o'clock noon on the third day of the annual session. Nomination for office shall be made orally, but the nominating speech must not exceed two minutes. The Councilors shall be elected at the same time on nomination by their respective district societies at the annual meetings of such societies preceding the annual session of the Association at which the vacancies occur, but if no nomination from a district society is brought before the Association, the nomination for Councilor may be presented from the floor. If there is no election on the first ballot, the three names receiving the highest number of ballots shall be voted on, the other names being dropped. If there is no election on the second ballot, the two names receiving the highest number of ballots shall be voted on until an election occurs. Delegates to the American Medical Association shall be elected at the same time and in the same manner.

Sec. 4. The members of the State Board of Health shall be nominated by their respective district societies at the annual meeting of such societies preceding the annual session of this Association, and in failure of nomination by district societies, they may be nominated by the delegates present from each of the district societies, all of which shall be ratified by this Association.

#### ARTICLE X.—FUNDS AND EXPENSES

Funds shall be raised by an equal per capita assess-

ment on each component society. The amount of the assessment shall not exceed the sum of \$10.00 per capita per annum. Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be approved by the Finance Committee before action is taken thereon.

#### ARTICLE XI.—RATIFICATION

The House of Delegates shall submit all questions before it to the Association for ratification.

#### ARTICLE XII.—THE SEAL

The Association shall have a common seal, with power to break, change or renew the same at pleasure.

#### ARTICLE XIII.—AMENDMENTS

Any amendment that may be offered to the Constitution shall lie over until the next annual session; and for its adoption at such session shall require a two-thirds vote of all present and voting.

### By-Laws

#### CHAPTER I.—MEMBERSHIP

Section 1. The name of a physician on the properly certified roster of members of a component society, which has paid its annual assessment, shall be *prima facie* evidence of membership in this Association.

Sec. 2. Any person who is under sentence of suspension or expulsion from a component society or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 3. Each member in attendance at the annual session shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

Sec. 4. Special membership. In addition to *Regular* members, component societies may elect to membership in their organizations, for membership in this Association, the following groups of members:

(a) *Honorary members.* Any member for old age, length of service, or other good reason, may be elected an honorary member of his county medical society, for membership in this Association. Such member shall, after election, be issued a certificate of honorary membership in this Association.

Non-resident physicians and resident or non-resident lay persons who have distinguished themselves in fields of endeavor devoted to the advancement of human welfare, may be nominated by county medical societies, or by the House of Delegates of this Association, for honorary membership in this Association. A county medical society shall not nominate for this class of membership more than one person each year. The name of such person shall be sent to the Secretary-Treasurer of this Association thirty days in advance of the annual session.



Such person shall be issued an appropriate certificate of honorary membership in this Association if, and when, he is elected to honorary membership by this Association.

(b) *Associate Members.* Eligible to this classification are (1) those regular members of component societies to whom the payment of dues would be an undue hardship; (2) interns, and (3) commissioned medical officers (see Chapter VII, Sec. 5 of these By-Laws) of the United States Army, the United States Navy and the United States Public Health Service while engaged actively in their respective services or if they have been retired on account of age or physical disability, or, after long and honorable service, under the provisions of an Act of Congress.

(c) Honorary and Associate members shall not be subject to the payment of dues to the State Association. They shall enjoy the privilege of full participation in the scientific, social and educational activities of this Association. They shall not vote nor hold office and do not receive the JOURNAL or benefits of Medical Defense.

Sec. 5. Any physician applying for membership in a component medical society of this Association, who has previously practiced in a county in which affiliation with a component society is provided, and who moves to another county without having affiliated with the medical society in the jurisdiction of previous residence, before he is admitted to membership, the cause of his lack of affiliation in the society of his previous residence shall be ascertained.

## CHAPTER II.—GENERAL MEETINGS

Section 1. All registered members may attend and participate in the proceedings and discussions of the general meetings. Visitors duly accredited to represent the associations of other states, or of the District of Columbia, not exceeding two in number for each organization, may attend upon, and participate in, the discussion of the general meeting, but shall not have a vote. Such delegates may read papers upon invitation of the Committee on Scientific Work. The general meetings shall be presided over by the President or by one of the Vice-Presidents.

Sec. 2. No papers or addresses before the Association, except those of the President and invited essayists, shall occupy more than fifteen minutes in their delivery; and no member shall speak longer than five minutes, nor more than once on any subject, provided that each essayist shall have five minutes in which to close the discussion of his paper.

Sec. 3. Entertainment. Any social entertainment which may be given by this Association shall be confined to the evening of the second day.

Sec. 4. Guests. Any physician not a resident of this State but a member of his state association, or any distinguished scientist not a physician, may be counted a guest during any annual session on invitation of the President, and shall be accorded the privilege of participating in the scientific work of that session.

## CHAPTER III.—HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet on the day preceding the first day of the annual session, the time to be fixed by the Committee on Scientific Work. It may adjourn from time to time as may be necessary

to complete its business; provided that its hours shall conflict as little as possible with the general meetings. The order of business shall be arranged as a separate section of the program.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members, and one for each fraction thereof, but each component society which has made its annual report and paid its assessment as provided in this Constitution and By-Laws shall be entitled to one delegate. Should the regular delegate from any county not be present at the meeting, the President shall appoint a substitute from that county to act.

Sec. 3. Twenty delegates present shall constitute a quorum.

Sec. 4. It shall, through its officers, council and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein it is dependent on the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest of such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until, if possible, every physician in every county of the State has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate and research work as well as home study, and shall endeavor to have the results utilized, and intelligently discussed in the county societies.

Sec. 8. It shall divide the State into councilor districts, one for each congressional district, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies and no others shall be members in such district societies.

Sec. 9. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate thereon.

## CHAPTER IV.—DUTIES OF OFFICERS

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and as far as practicable, shall visit, by appointment,

the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

In order to give him a better opportunity of becoming more fully acquainted with his duties and with the needs of the Association, the President shall be elected one year prior to taking office. During this time he shall be known as President-Elect and shall be ex-officio member of standing committees, and shall make recommendations at the next annual session.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of the President's death, resignation or removal, the Vice-Presidents, in their order, shall succeed him.

Sec. 3. The Secretary-Treasurer shall give bond in the sum of One Thousand Dollars. He shall demand and receive all funds due the Association, together with the bequests and donations.

Sec. 4. The Secretary-Treasurer shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep the minutes of their respective proceedings in separate record books. He shall be ex-officio Secretary of the Council. He shall be custodian of all record-books and papers belonging to the Association. He shall provide for the registration of the members, delegates and accredited visitors at the annual session. He shall, with the co-operation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and on request transmit a copy of this list to the American Medical Association. He shall aid the Councilors in the organization and improvement of the county societies in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties. He shall employ such assistants as may be ordered by the House of Delegates with the approval of the Association, and shall make an annual report to the Association. He shall supply each component society with the necessary blanks for making their annual reports; shall keep an account with the component societies, charging against each society its assessment and collect the same. Acting with the Committee on Scientific Work, he shall prepare and issue all programs. The amount of his salary shall be fixed by the Association. He shall be editor of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

He shall furnish a balance sheet at each annual meeting for the past fiscal year to be published in the JOURNAL. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and from whom and all moneys disbursed, to whom, and for what purpose, with vouchers attached. A fiscal year includes the period of time between the first day of May and the last day of April.

#### CHAPTER V.—COUNCIL

Section 1. The Council shall meet on the day preceding the annual session and daily during the session, and

at such other times as necessity may require, subject to the approval of the President. It shall meet on the last day of the annual session of the Association to organize and outline work for the ensuing year. It shall elect a chairman and clerk, who, in the absence of the Secretary of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall be the business body of the Association and attend to the business of the Association in the interim between meetings.

Sec. 2. Each Councilor shall be organizer and peacemaker for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the conditions of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the House of Delegates on a properly itemized statement, but this shall not be considered to include his expense in attending the annual session of the Association. Each Councilor may appoint a Vice-Councilor to assist him in the performance of his duties in his district.

Sec. 3. The Council shall be the board of censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to the members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of a component society, on which an appeal is taken from the decision of an individual Councilor, or to which attention has been called by the Councilor or interested members. It shall hear and decide all questions affecting unethical conduct on the part of any members of any annual session, and its decision in all such matters shall be final when ratified by the Association.

Sec. 4. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and the societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 5. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association, and shall have authority to appoint such assistants to the editor as it deems necessary. It shall manage and conduct the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, which is the organ of the Association, and all money paid into the treasury as dues shall be received as subscriptions to the JOURNAL.

All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Secretary-Treasurer of the Association. As the Finance Committee it shall annually



audit the accounts of the Secretary-Treasurer and other agents of this Association, and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Association during the year, and the amount of all other property belonging to the Association under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of the Secretary-Treasurer, the Council shall fill the vacancy until the next annual election.

Sec. 6. All reports on scientific subjects and all scientific discussions and papers heard before the Association, shall be referred to the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA for publication. The editor, with the consent of the Councilor for the district in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Sec. 7. All commercial exhibits during the annual sessions shall be within the control and direction of the Council.

Sec. 8. In the absence of a Councilor and Vice-Councilor the President is empowered to appoint a representative from the district as acting Councilor, who shall have full rights and powers of a Councilor.

Sec. 9. Each Councilor shall render at every session a written report of each county in his district.

Sec. 10. Any member of the Council who fails to attend two regular successive sessions of the Council, or whose district does not show evidence of the performance of his duties during the year, unless he renders an acceptable excuse to the Council, is subject to have his position declared vacant by the President and a successor appointed by the President.

## CHAPTER VI.—COMMITTEES

Section 1. The standing committees shall be as follows:

A Committee on Scientific Work.

A Committee on Public Policy and Legislation.

A Committee on Arrangements.

A Committee on Medical Defense, and such other committees as may be necessary.

Sec. 2. The Committee on Scientific Work shall consist of four members, one of whom shall be the Secretary-Treasurer. The other three members shall be appointed for terms of one, two, and three years, respectively. The vacancy which will occur each year by the expiration of the term of one member shall be filled by the President with an appointment of three years. The member who has the shortest time to serve shall be chairman. The committee shall determine the character and scope of the scientific proceedings of the Association for each session. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented.

This By-Law shall not prohibit the Committee on Scientific Work from inviting not more than two distinguished members of the national organization to deliver addresses or read papers at any annual meeting.

Sec. 3. The Committee on Public Policy and Legisla-

tion shall consist of three members and the President and Secretary, the Commissioner of Health of the State of Georgia, and a sub-committee of three members from each Councilor District appointed by the chairman when needed. It shall represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs and elections.

Sec. 4. The Committee on Arrangements shall be appointed by the component society in which the annual session is to be held. It shall provide suitable accommodations for the meeting places of the Association and of the House of Delegates and their respective committees, and shall have general charge of all arrangements. Its chairman shall report an outline of the arrangements to the Secretary-Treasurer for publication in the program, and shall make additional announcements during the session as occasion may require.

Sec. 5. The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer of the Association shall be members. The other members, one of whom shall act as chairman of the committee, shall be elected by the Council for a period of five years. Those elected at this meeting (April 19, 1916), shall serve one, three and five years, respectively.

It shall be the duty of the Committee on Medical Defense to investigate and defend all damage suits against the Medical Association of Georgia; to investigate all claims of civil malpractice made against its members; to take full charge of such cases, which after investigation, they decide to be proper cases for defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court cost usual to such litigation, and reasonable fees for local attorneys as shall be arranged by General Counsel. Provided that any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate the Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. They shall be empowered to contract with such agents or attorneys as they may deem necessary for the proper carrying out of this By-Law.

The assistance for defense, as herein provided, shall be available only to members of the Medical Association of Georgia in good standing. Any member who has not paid his annual dues by April 1st shall not be considered in good standing in the application of this By-Law.

Any member or members of the Association threatened with suit for civil malpractice shall immediately communicate with the Secretary of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. The Secretary shall proceed immediately to investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The members sued, or threatened with suit, shall be con-



sulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may also, at its discretion, arrange to prosecute illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

#### CHAPTER VII.—COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Association, or those which may hereafter be organized in the State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charter shall be issued thereto.

Sec. 3. Charters shall be issued only on approval of the Council, and shall be signed by the President and Secretary of this Association. The Association shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county.

Sec. 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association, every legally registered white physician who does not practice or claim to practice, nor lend his support to any exclusive system of medicine, shall be eligible to membership. Physicians who have been legally registered in other states or who have been licensed by the National Board of Medical Examiners, or who are employed as teachers in the medical schools, or are in the service of the State, a county, a municipality, or the United States Government other than the regular medical corps of the United States Army, the United States Navy and the United States Public Health Service, may be accepted for membership in county medical societies, for membership in this Association, provided they meet the requirements of regular membership. Before a charter is issued to any county medical society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. No matter what the unethical conduct or discipline of the members of the county society may be, both plaintiff and defendant shall have the right to appeal to the Council, whose decision shall be final when ratified by the Association.

Sec. 7. In hearing appeals the Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in

district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component county society moves to another county in this State, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he moves, such members shall be considered to be in good standing in the county society from which he was certified and in the Medical Association of Georgia to the end of the period for which his dues have been paid.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

Sec. 10. Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. At some meeting in advance of the annual session of this Association, each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each fifty members, or fraction thereof, and the Secretary of the society shall send a list of such delegates to the Secretary of this Association at least ten days before the annual session.

Sec. 12. The Secretary of each component society shall keep a roster of its members, and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Sec. 13. The Secretary of each component society shall forward its assessment, together with its roster of officers and members, list of delegates, and lists of non-affiliated physicians of the county, to the Secretary of this Association each year, thirty days before the annual session.

Sec. 14. Any county society which fails to pay its assessment, or make the report required on or before April 1 of each year, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association, or of the House of Delegates, until such requirement has been met.

Sec. 15. The Secretary of each county society shall report to the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

## CHAPTER VIII.—RULES AND ETHICS

Section 1. The deliberation of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2. All papers read before the Association shall become its property. Each paper shall be deposited with the Secretary when read, and if this is not done it shall not be published.

Sec. 3. The principles of medical ethics of the American Medical Association shall be those of this Association.

Sec. 4. Any member of this Association, on locating in a new place for practicing his profession, may place his professional card, containing name, address, telephone number, and statement as to whether or not his practice will be limited to any particular class of diseases, in the local paper for a period of not longer than one month. The placing of such card for this period of time shall not be considered unethical. The use of the word "specialist" by any member in connection with his name in any newspaper, telephone directory, or other public places, shall be considered unethical.

## CHAPTER IX.—AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the Association after the amendment has lain on the table for one day.

RESOLUTIONS,  
MEDICAL ASSOCIATION OF GEORGIA

1921

Resolved, That a member who sends in a title of a paper to be placed on the program and is not present to read the paper, shall pay the penalty of not having an opportunity to appear on the program for two years, unless he presents an excuse acceptable to the Committee on Scientific Work.

1922

Be it Resolved, That the House of Delegates recommend that the Committee on Scientific Work make available on the program of the State Association space for two papers from each Council district; that a definite time be assigned for reading and discussion of each of these papers, and they be given precedence over all other business. The said papers are to be selected by the Committee on Scientific Work, and, in case a writer does not respond when his name is called, some paper will be substituted and the schedule not deranged. The President ruled that this resolution is only a recommendation and not a law.

1923

Resolved, That the delegates to the A. M. A. elected at this and succeeding meetings of the Medical Association of Georgia be installed January 1st, following their election, and that their term of service run for two years thereafter. And be it further

Resolved, That our delegates be authorized to attend the regular and any called meeting of the House of Delegates of the American Medical Association during the term to which they are elected.

1929

Resolved, That in order to expedite the business of the House of Delegates, all reports of special and regular committees of the Association involving matters of public policy, legislation or appropriation of the funds of the Association be submitted in writing to the Secretary of the Association a sufficient time in advance of the regular annual session, about March 15th, to permit the publication of said recommendations either in the official program prior to the session or in a special circular that shall be mailed to the constituent societies, in order that the delegates may be advised of the proposed changes.

1944

Resolved, That the House of Delegates set the amount of dues at \$7.00 per capita for the year 1945.

## COUNTIES REPORTING FOR 1946

*Baldwin County Medical Society*

The Baldwin County Medical Society announces the following officers for 1946:

President—Z. S. Sikes, Milledgeville  
Vice-President—G. L. Echols, Milledgeville  
Secretary-Treasurer—J. D. Combs, Milledgeville  
Delegate—C. G. Cox, Milledgeville  
Alternate Delegate—C. B. Fulghum, Milledgeville

*Bartow County Medical Society*

The Bartow County Medical Society announces the following officers for 1946:

President—Hugh S. McGowan, Cartersville  
Vice-President—H. B. Bradford, Cartersville  
Secretary-Treasurer—A. L. Horton, Cartersville  
Delegate—H. B. Bradford, Cartersville.

*Brooks County Medical Society*

The Brooks County Medical Society announces the following officers for 1946:

President—A. B. Jones, Jr., Quitman  
Vice-President—L. A. Smith, Quitman  
Secretary-Treasurer—Harry A. Wasden, Quitman  
Delegate—Harry A. Wasden, Quitman

*Bulloch-Candler-Evans Counties Medical Society*

The Bulloch-Candler-Evans Counties Medical Society announces the following officers for 1946:

President—John Mooney, Jr., Statesboro  
Vice-President—Elizabeth Fletcher, Statesboro  
Secretary-Treasurer—L. H. Griffin, Claxton  
Delegate—A. B. Daniel, Claxton  
Alternate Delegate—R. L. Kennedy, Metter

*Burke County Medical Society*

The Burke County Medical Society announces the following officers for 1946:

President—W. W. Hillis, Sardis  
Vice-President—W. C. McCarver, Vidette  
Secretary-Treasurer—W. D. Lundquist, Waynesboro  
Delegate—J. M. Byne, Jr., Waynesboro  
Alternate Delegate—W. R. Lowe, Midville

## WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.  
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.  
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.  
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.  
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.  
 Corresponding Secretary—Mrs. Alex Russell, Winder.  
 Treasurer—Mrs. Ralph Fowler, Marietta.  
 Historian—Mrs. W. W. Puett, Norcross.  
 Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.  
 Press and Publicity—Mrs. Charles Daniel, College Park.



MRS. W. T. RANDOLPH  
 Winder  
 President, 1944-46

### INVITATIONS

The Woman's Auxiliary to the  
 Bibb County Medical Society  
 invites

The Woman's Auxiliary to the  
 Medical Association of Georgia  
 to  
 Macon

May 7-8-9-10, 1946

MRS. WALTER MOBLEY, *President*

Dear Auxiliary Members:

The Twenty-First Convention of the Woman's Auxiliary to the Medical Association of Georgia will meet in Macon May 7-10. May I extend to every Auxiliary member and to every doctor's wife in Georgia an invitation to attend this convention.

We have not met in convention since 1944 and there are old ties of friendship to renew and new ones to be made. Be sure to make your reservations early since accommodations are limited.

A cordial welcome awaits us in Macon and everything will be done to make our stay pleasant by our hospitable hostesses, the Auxiliary to the Bibb County Medical Society.

Looking forward to seeing each of you, and with keen anticipation of a successful meeting, I am

Sincerely yours,

MRS. WM. T. RANDOLPH, *President*,  
 Woman's Auxiliary to the Medical  
 Association of Georgia.

### CONVENTIONS AND PRESIDENTS

Honorary President for Life—Mrs. James N. Brawner, Sr., Atlanta.

1924—Augusta—(Organization)—Mrs. C. W. Roberts, Atlanta, Temporary Chairman

1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta

1926—Albany—Mrs. William H. Myers, Savannah

1927—Athens—Mrs. C. W. Roberts, Atlanta

1928—Savannah—Mrs. Paul Holliday, Athens (Mrs. J. C. Moore, Gaffney, S. C.)

1929—Macon—Mrs. Charles C. Hinton, Macon

1930—Augusta—Mrs. Marion T. Benson, Atlanta

1931—Macon—Mrs. Charles C. Harrold, Macon

1932—Savannah—Mrs. Ralston Lattimore, Savannah

1933—Macon—Mrs. S. T. R. Revell, Louisville

1934—Augusta—\*Mrs. J. Bonar White, Atlanta

1935—Atlanta—Mrs. J. E. Penland, Waycross

1936—Savannah—Mrs. Ernest R. Harris, Winder

1937—Macon—Mrs. William R. Dancy, Savannah

1938—Augusta—Mrs. Ralph Chaney, Augusta

1939—Atlanta—Mrs. Warren A. Coleman, Eastman

1940—Savannah—Mrs. Eustace A. Allen, Atlanta

1941—Macon—Mrs. H. G. Banister, Ila

1942—Augusta—Mrs. Lee Howard, Savannah

1943—Atlanta—Mrs. Lon J. King, Macon

1944—Savannah—Mrs. Olin S. Cofer, Atlanta

\*Deceased

### PROGRAM

TWENTY-FIRST ANNUAL CONVENTION

WOMAN'S AUXILIARY TO THE

MEDICAL ASSOCIATION OF GEORGIA

Dempsey Hotel, Macon

May 7-10, 1946



## OFFICERS AND COMMITTEES

*Executive Board*

President—Mrs. William T. Randolph, Winder.  
 President-Elect—Mrs. Lucius N. Todd, Augusta.  
 First Vice-President—Mrs. Edgar H. Greene, Atlanta.  
 Second Vice-President—Mrs. L. W. Williams, Savannah.  
 Third Vice-President—Mrs. Leonard R. Massengale, Augusta.  
 Recording Secretary—Mrs. Charles Usher, Savannah.  
 Corresponding Secretary—Mrs. Alex B. Russell, Winder.  
 Treasurer—Mrs. Ralph Fowler, Marietta.  
 Parliamentarian—Mrs. Lee Howard, Savannah.  
 Chairmen of Standing Committees  
 Past Presidents of State Auxiliary.  
 District Managers  
 Presidents of County Auxiliaries.

*Chairmen of Standing Committees*

Organization—Mrs. Lucius N. Todd, Augusta.  
 Health Education—Mrs. Edgar H. Greene, Atlanta.  
 Hygeia—Mrs. L. W. Williams, Savannah.  
 Scrapbook—Mrs. Leonard R. Massengale, Augusta.  
 Public Relations—Mrs. J. Harry Rogers, Atlanta.  
 Visual Education—Mrs. W. D. Hall, Calhoun.  
 Legislation—Mrs. Francis M. Martin, Shellman.  
 Press and Publicity—Mrs. Charles Daniel, College Park.  
 Doctors' Day—Mrs. C. B. Almand, Winder.  
 Research in Romance of Medicine—Mrs. D. H. Garrison, Clarkesville.  
 Student Loan Fund—Mrs. H. G. Banister, Ila.  
 Jane Todd Crawford Memorial Fund—Mrs. W. M. Flanagan, Waycross.  
 Revisions—Mrs. Ralph Chaney, Augusta.  
 Archives—Mrs. Eustace A. Allen, Atlanta.  
 Exhibits—Mrs. J. Lon King, Macon.  
 Mrs. James N. Brawner Trophy—Mrs. Olin S. Cofer, Atlanta.  
 Bulletin—Mrs. Stacy Howell, Atlanta.  
 Wartime Service—Mrs. R. V. Martin, Savannah.

## DISTRICT MANAGERS

First District—Mrs. W. E. Simmons, Metter.  
 Second District—Mrs. J. A. Redfearn, Albany.  
 Third District—Mrs. J. L. Gallemore, Perry.  
 Fifth District—Mrs. B. L. Shackelford, Atlanta.  
 Sixth District—Mrs. Sam Anderson, Milledgeville.  
 Seventh District—Mrs. W. E. Mitchell, Smyrna.  
 Eighth District—Mrs. T. V. Willis, Brunswick.  
 Ninth District—Mrs. S. T. Ross, Winder.  
 Tenth District—Mrs. G. L. Loden, Colbert.

## PRESIDENTS OF COUNTY AUXILIARIES

Baldwin County—Mrs. Sam Anderson, Milledgeville.  
 Barrow County—Mrs. Alex B. Russell, Winder.  
 Bibb County—Mrs. Walter Mobley, Macon.  
 Bulloch-Candler-Evans Counties—  
 Burke-Jenkins-Screven Counties—  
 Chatham County (Georgia Medical Society)—Mrs. R. L. Neville, Savannah.  
 Cherokee-Pickens Counties—  
 Clarke-Oglethorpe-Oconee-Madison Counties—Mrs. H. W. Birdsong, Athens.  
 Cobb County—Mrs. Regina Rambo Benson, Marietta.  
 Dodge County—Mrs. I. J. Parkerson, Eastman.  
 Dougherty County—Mrs. Alex R. Freeman, Albany.  
 Fulton County—Mrs. D. R. Longino, Atlanta.

Glynn County—Mrs. T. V. Willis, Brunswick.  
 Gordon County—Mrs. R. D. Walter, Calhoun.  
 Gwinnett County—Mrs. W. W. Puett, Norcross.  
 Habersham County—Mrs. J. B. Jackson, Clarkesville.  
 Houston-Peach Counties—Mrs. J. L. Gallemore, Perry.  
 Macon County—Mrs. S. C. Ligin, Montezuma.  
 Muscogee County—Mrs. W. C. Cook, Columbus.  
 Polk County—Mrs. John McGehee, Cedartown.  
 Randolph-Terrell Counties—  
 Richmond County—Mrs. Henry Harper, Augusta.  
 Sumter County—  
 Tift County—  
 Ware County—Mrs. B. H. Minchew, Waycross.  
 Washington County—Mrs. J. B. Dillard, Davisboro.

## COMMITTEES

## GENERAL CHAIRMEN

Mrs. Charles J. Woods  
 Mrs. J. P. Holmes  
 CREDENTIALS AND REGISTRATION  
 Mrs. J. C. Anderson  
 Mrs. W. R. Golsan  
 Mrs. J. D. Applewhite  
 Mrs. Charles F. Cooper, Jr.  
 Mrs. Lemuel F. James

## DECORATIONS

Mrs. D. T. Henderson  
 Mrs. O. R. Thompson  
 Mrs. Leon D. Porch  
 Mrs. Devereaux W. Jarrett  
 Mrs. H. G. Weaver

## HOSPITALITY

Mrs. C. H. Richardson  
 Mrs. C. C. Harrold  
 Mrs. J. Lon King  
 Mrs. W. W. Baxley  
 Mrs. Charles J. Woods

## EXHIBITS

Mrs. J. Lon King  
 Mrs. W. L. Bazemore  
 Mrs. Robert McAllister

## LUNCHEON

Mrs. O. F. Keen  
 Mrs. J. A. Fountain  
 Mrs. Milford B. Hatcher  
 Mrs. F. M. Houser  
 Mrs. Samuel E. Patton  
 Mrs. T. E. Rogers  
 Mrs. W. Charles Boswell

## TEA

Mrs. Ernest Corn  
 Mrs. W. A. Newman  
 Mrs. C. L. Anderson  
 Mrs. R. G. Newton  
 Mrs. Thomas Harrold  
 Mrs. W. L. Bazemore  
 Mrs. Hall Farmer  
 Mrs. C. H. Richardson

## PAGES

Mrs. W. W. Chrisman  
 Mrs. Roland Brown  
 Mrs. Robert Watts Edenfield

TIMEKEEPER

Mrs. J. Emory Clay

PUBLICITY

Mrs. J. Lon King

Mrs. W. W. Baxley

TRANSPORTATION

Mrs. W. W. Baxley

Mrs. O. R. Thompson

Mrs. J. Lon King

Mrs. J. P. Holmes

Mrs. D. T. Henderson

Mrs. J. Emory Clay

BANQUET

Mrs. C. C. Hinton

Mrs. J. C. Anderson

Mrs. W. W. Chrisman

Mrs. C. H. Richardson

Mrs. W. W. Baxley

Mrs. Allen Smith

Mrs. D. T. Henderson

Mrs. Wm. L. Barton

ARRANGEMENTS

Mrs. Charles J. Woods

Mrs. J. P. Mobley

Mrs. W. E. Mobley

PROGRAM

HEADQUARTERS, DEMPSEY HOTEL

TUESDAY, MAY 7, 1946

ENTERTAINMENT AND PROGRAM

*Executive Board Meeting*

*Registration*

Tuesday, May 7, 5:30 to 7:00 P. M.—Dempsey Hotel

Wednesday, May 8, 10:00 to 12:30 P. M.—General Meeting

Wednesday, May 8, 1:00 P. M.—Luncheon, Dempsey Hotel.

Wednesday, May 8, 5:00 to 6:00 P. M.—Tea, Wesleyan Conservatory. Given by the Woman's Auxiliary to the Bibb County Medical Society.

Wednesday, May 8, 8:00 P. M.—Public Meeting, Medical Association of Georgia.

Thursday, May 9, 10:00 to 12:30 P. M.—General Meeting.

Thursday, May 9, 7:30 P. M.—Joint Banquet. All members of the Medical Association and their wives are invited.

PROGRAM

Wednesday, May 8, 1946, 10:00 A. M.

*Eastern Standard Time*

Call to Order by the President, Mrs. Wm. T. Randolph, Winder.

*Invocation*

The Rev. Father Harrold A. Gaudin, S. J., St. Joseph's Catholic Church, Macon.

*Address of Welcome*

Mrs. Walter F. Mobley, Macon, President, Woman's Auxiliary to the Bibb County Medical Society.

*Response to Address of Welcome*

Mrs. J. E. Billings, Calhoun.

*Introduction of Officers and Honor Guests*

Mrs. J. Lon King, Macon.

*Report of Advisory Committee to the Woman's Auxiliary*

Dr. Eustace A. Allen, Atlanta, Chairman.

*Address*

Dr. Cleveland Thompson, Millen, President, Medical Association of Georgia.

*Address*

Mrs. W. W. Potter, Concord, Tenn., President, Woman's Auxiliary to the Southern Medical Association.

*Rules Governing Convention Procedure*

Mrs. Lee Howard, Savannah, Parliamentarian.

*Introduction of Pages*

*Report of Executive Committee*

*Report of Entertainment Committee*

Mrs. Charles J. Woods, Macon.

*Reports of District Managers and County Presidents*

*Report of Registration Committee*

Mrs. S. J. Anderson, Macon.

*Business*

*Reading of Minutes*

*Adjournment*

PROGRAM

Thursday, May 9, 1946, 10:00 A. M. Dempsey Hotel  
Call to Order by the President, Mrs. Wm. T. Randolph, Winder.

*Invocation*

Dr. Eric Oesterle, Macon, Pastor, Tattnell Square Baptist Church.

*Addresses*

Mrs. Durice D. Hanson, Atlanta, Executive Secretary, Georgia State Nurses' Association.

Lt. Frances Nash, A. N. C., Fort McPherson.

Dr. Ralph Chaney, Augusta, President-Elect, Medical Association of Georgia.

*Memorial Service*

Mrs. Harold C. Atkinson, Macon.

*Report of Meeting of Auxiliary to the American Medical Association*

Mrs. Eustace A. Allen, Atlanta

*Report of Meeting of Auxiliary to the Southern Medical Association*

Mrs. Allen H. Bunce, Atlanta.

*Reports of Officers*

*Report of Auditing Committee*

*Report of Resolutions Committee*

*Report of Registration Committee*

*Report of Awards Committee*

*Report of Courtesy Committee*

BUSINESS

*Report of Nominating Committee*

*Election of Officers*

*Presentation of President's Pin to Retiring President*

Mrs. Joseph Yampolsky, Atlanta.

*Announcement by President*

Mrs. Lucius N. Todd, Augusta.

*Adjournment*

Thursday, May 10, 1946

*Post-Convention Board Meeting*

Mrs. Lucius N. Todd, Augusta.

RULES TO GOVERN THE CONVENTION

1. To gain recognition, a delegate is requested to rise address the chair, give her name and Auxiliary.
2. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.

3. Reports shall not be read from Auxiliaries which are not represented by delegates but shall be filed with the Secretary.
4. All original motions or resolutions shall be made by submitting two copies: one to the Resolutions Committee and one to the Recording Secretary.
5. Reports of delegates and district managers are limited to two minutes.
6. No one is entitled to vote before she is registered.

Whispering conversations greatly retard the business of a meeting. Please be prompt. Meetings will begin promptly at the time stated in the program. To expedite the business, reports must conform to the time allotted.

#### PROPOSED NEW U. S. P. HYDROPHYLIC OINTMENT BASES

Many readers will be interested in two new ointment base formulas proposed for inclusion in the forthcoming Pharmacopoeia Thirteenth Revision. One of these is of the "water-absorption" type, and the other is "water-washable", that is readily removed from the skin by washing with water.

*Hydrophylic Petrolatum* is the title proposed for the "water-absorption" base which is anhydrous but readily mixes with water or most aqueous solutions. The formula proposed has been offered commercially for some time and is reported as having been received very well by clinicians and pharmacists. The formula is as follows:

##### *Hydrophylic Petrolatum*

Cholesterol .....	10 Gm.
Stearyl Alcohol .....	30 Gm.
White Wax .....	80 Gm.
Wool Fat (anhydrous) .....	150 Gm.
White Petrolatum .....	730 Gm.

To make .....1000 Gm.

Melt the ingredients together on a water bath, mix thoroughly, remove from the water bath, and stir until the mixture congeals.

*Hydrophylic Ointment*—This is the title proposed for the ointment base of the "washable" type. It was developed by Professor Louis C. Zopf, after a series of laboratory and clinical investigations at the University of Iowa College of Pharmacy and Hospital. The proposed formula is as follows:

##### *Hydrophylic Ointment*

Stearyl Alcohol .....	250 Gm.
White Petrolatum .....	250 Gm.
Glycerin .....	120 Gm.
Sodium Lauryl Sulfate .....	10 Gm.
Methyl Parahydroxybenzoate .....	0.25 Gm.
Propyl Parahydroxybenzoate .....	0.15 Gm.
Distilled Water .....	369 Gm.

To make about .....1000 Gm.

Melt the stearyl alcohol and white petrolatum on a water bath and warm to 75 deg. Dissolve the sodium lauryl sulfate and methyl parahydroxybenzoate in the glycerin and water, warm to 75 deg., and add this solution, with stirring, to the warm stearyl alcohol and white petrolatum. Stir the ointment until congealed.

#### EMORY UNIVERSITY OPHTHALMOLOGICAL SEMINAR

You are cordially invited to be the guest of Emory University at an ophthalmological seminar to be held in Atlanta April 4, 5, 6, 1946.

Emory University will celebrate the One Hundredth Anniversary of the birth of Abner Wellborn Calhoun, M.D., L.L.D., who was born April 16, 1845, and died August 21, 1910, the first professor of ophthalmology of the Atlanta Medical College.

#### P R O G R A M

Thursday, April 4, 1946

##### ACADEMY OF MEDICINE

- 6:30 P. M. Buffet Supper  
 7:30 P. M. "Dedication of Auditorium," Dr. James Edgar Paullin, Atlanta, Ga.  
 8:30 P. M. "Myasthenia Gravis," Dr. Frank B. Walsh, Baltimore, Md.  
 9:00 P. M. "Medical Ophthalmology," Dr. Walter I. Lillie, Philadelphia, Pa.

Friday, April 5, 1946.

##### GRADY HOSPITAL LECTURE ROOM

- 10:00 A. M. "Diplopia," Dr. Walter I. Lillie, Philadelphia, Pa.  
 11:00 A. M. "The Clinical Meaning of Exophthalmos," Dr. William Benedict, Rochester, Minn.  
 Luncheon. Guest of Grady Hospital.

##### ACADEMY OF MEDICINE

- 3:00 P. M. "Eye Changes in Diabetes," Dr. Derrick Vail, Cincinnati, O.  
 4:00 P. M. "Nasopharyngeal Tumors," Dr. Frank B. Walsh, Baltimore, Md.  
 6:30 P. M. Dinner. Biltmore Hotel. Guest of Emory University.

##### ACADEMY OF MEDICINE

- 8:00 P. M. "Ocular Therapeutics in Glaucoma," Dr. Parker Heath, Detroit, Mich.  
 9:00 P. M. "Treatment of Detachment of the Retina," Dr. John Dunnington, New York, N. Y.  
 Saturday, April 6, 1946.

##### ACADEMY OF MEDICINE

- 10:00 A. M. "Glaucoma in Diabetes," Dr. William Benedict, Detroit, Mich.  
 11:00 A. M. "Surgical Treatment of the Vertical Deviations," Dr. John Dunnington, New York, N. Y.

Luncheon. Biltmore Hotel. Guest of Department of Ophthalmology.

##### ACADEMY OF MEDICINE

- 3:00 P. M. "Random Notes on Ocular Surgery," Dr. Parker Heath, Detroit, Mich.  
 3:30 P. M. "Ocular Signs of Subdural Hematoma," Dr. Frank B. Walsh, Baltimore, Md.  
 4:30 P. M. "The Clinical Diagnosis of Retrobulbar Neuritis," Dr. Walter I. Lillie, Philadelphia, Pa.

##### ACADEMY OF MEDICINE

- 8:00 P. M. "Preparation of the Patient for Cataract Operation," Dr. William Benedict, Detroit, Mich.  
 9:00 P. M. "The Circulation of the Optic Nerve and its Influence on Disease," Dr. Derrick Vail, Cincinnati, O.



## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1008 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, WALnut 8911; residence, JACKson 7979.

### PUBLIC HEALTH NURSING WEEK, APRIL 7-13, 1946

MRS. BESSIE F. SWAN, *Associate Director*,  
Division of Public Health Nursing  
Georgia Department of Public Health  
*Atlanta*

One of the best allies of the private physician is the public health nurse. Busy as he is, the private physician does not always have the time or opportunity to follow through on the details of his instructions to patients. The public health nurse, because of her training and experience, is especially prepared to interpret the physician's orders to the patient and his family. She does this through visits to the home where she demonstrates nursing procedures and holds discussions of the particular health problems of the entire family.

The public in general is not uniformly aware of the services which can be rendered by the public health nurse after the physician has made his call. That is why a special week known as "Know Your Public Health Nurse Week"—April 7-13—has been set aside as a means of calling attention to this fact. On a country-wide basis it is sponsored by the National Organization for Public Health Nursing, and in this state by the Georgia State Organization for Public Health Nursing.

Local committees have been formed throughout the State and during this week they will, through many means and media, seek to accomplish eight definite objectives:

1. To reach people who are not already interested in public health nursing services.
2. To spread the message that public health nursing services are for everybody to use.
3. To interest more nurses in entering the field of public health nursing.
4. To interest more high school and college girls in choosing public health nursing as a career.
5. To encourage everybody to "keep healthy."
6. To interest more people to lend their time

as volunteers. Hundreds of volunteers served faithfully during wartime.

Their interest and help are just as vitally needed now to extend and enrich the health services given to a community.

7. To help relieve the pressure on hospitals by calling attention to the fact that part-time professional nursing service is available to people at home.

8. To stimulate the organization and enlargement of services wherever they are needed.

In pressing forward to obtain these objectives, efforts will be made to acquaint every community with the fact that the visiting nurse, city or county or regional nurse, school nurse and industrial nurse are *all* public health nurses; that the public health nurse is a registered, graduate nurse expected to have special preparation in teaching health; and that public health nursing service has a thorough preventive and educational, as well as remedial, side.

"Know Your Public Health Nurse Week" has its foundation in numerous surveys made throughout the United States which showed that too few of a wide and ailing section of the population were not sufficiently informed about the services rendered by the "blue-clad nurse with the black or brown bag," nor were the informed persons taking advantage of what she could do for them and their families.

This year special emphasis will be placed upon the recruiting of desirable young women for the field of public health nursing. There is a pressing need for more public health nurses. In the United States at large we have one public health nurse to approximately every 6,000 persons. To obtain the desirable ratio of one public health nurse to each 2,000 of the population would require at least 65,000 public health nurses, about 45,000 more than we have now. In Georgia's various city and county health departments alone there is need for 200 additional public health nurses. With the need for expansion of public health facilities throughout the State, recruiting is indeed a challenge to all.

## SPECIAL ANNOUNCEMENT

Student Nurse Recruitment Month is proclaimed for February 15-March 15, 1946, by Mayor William B. Hartsfield of Atlanta. Dr. M. D. Collins, Superintendent of Georgia Schools, and Miss Ida Jarrell, Superintendent of Atlanta Schools cooperate with State Nursing Council in promoting a State-wide Poster Contest for best posters illustrating nursing education of nursing service. This recruitment campaign is launched and designed to acquaint people with the role of qualified nursing personnel in all health programs, and the opportunities for well qualified women veterans such as Medical Technicians, WACS, WAVES, High School or College girls to enter a broad and varied service which the nursing profession offers. Dr. Collins emphasized the fact that an efficient and adequate supply of nurses will insure a rise in the level of Georgia's health care. There are at this time over 180 vacancies in the accredited schools of nursing of Georgia, for the March, June and September classes. Speakers from the Georgia League of Nursing Education are available and request opportunities to discuss nursing education with high schools, colleges and other audiences to explain the critical situation in the shortage of nurses. Medical auxiliaries are approached through the co-chairman, Mrs. James N. Brawner, Sr., for their support and assistance in this Student Nurse Recruitment Campaign.

## COUNTIES REPORTING FOR 1946

*Carroll County Medical Society*

The Carroll County Medical Society announces the following officers for 1946:

President—W. Steve Worthy, Carrollton  
Vice-President—R. L. Berry, Villa Rica  
Secretary-Treasurer—H. L. Barker, Carrollton  
Delegate—S. F. Scales, Carrollton

*Clarke-Madison-Oconee Counties Medical Society*

The Clarke-Madison-Oconee Counties Medical Society announces the following officers for 1946:

President—John A. Simpson, Athens  
Vice-President—Guy O. Wheelchel, Athens  
Secretary-Treasurer—Loree Florence, Athens  
Delegate—Sam M. Talmadge, Athens  
Alternate Delegate—Harry E. Talmadge, Athens

*Clayton-Fayette Counties Medical Society*

The Clayton-Fayette Counties Medical Society announces the following officers for 1946:

President—J. R. Wallis, Lovejoy  
Vice-President—Y. R. Coleman, Jonesboro  
Secretary-Treasurer—T. J. Busey, Fayetteville  
Delegate—Y. R. Coleman, Jonesboro

*Cobb County Medical Society*

The Cobb County Medical Society announces the following officers for 1946:

President—W. H. Perkinson, Marietta  
Vice-President—F. P. Lindley, Powder Springs

Secretary-Treasurer—L. L. Welch, Marietta  
Delegate—E. S. Davis, Acworth  
Alternate Delegate—R. W. Fowler, Marietta

*Coffee County Medical Society*

The Coffee County Medical Society announces the following officers for 1946:

President—B. O. Quillian, Douglas  
Secretary-Treasurer—R. L. Johnson, Douglas  
Delegate—Sage Harper, Ambrose  
Alternate Delegate—Dan A. Jardine, Douglas

*Dougherty County Medical Society*

The Dougherty County Medical Society announces the following officers for 1946:

President—W. M. Feild, Albany  
Vice-President—A. J. James, Albany  
Secretary-Treasurer—I. M. Lucas, Albany  
Delegate—H. M. McKemie, Albany  
Alternate Delegate—N. R. Thomas, Albany

*Douglas County Medical Society*

The Douglas County Medical Society announces the following officers for 1946:

President—J. G. Bussey, Austell  
Vice-President—T. B. Taylor, Douglasville  
Secretary-Treasurer—C. V. Vansant, Douglasville  
Delegate—C. V. Vansant, Douglasville  
Alternate Delegate—J. G. Bussey, Austell

*Bibb County Medical Society*

The Bibb County Medical Society announces the following officers for 1946:

President—W. W. Baxley, Macon  
President-Elect—C. N. Wasden, Macon  
Vice-President—R. W. McAllister, Macon  
Secretary-Treasurer—A. M. Phillips, Macon  
Delegate—W. W. Baxley, Macon  
Delegate—J. B. Kay, Byron  
Alternate Delegate—J. D. Applewhite, Macon  
Alternate Delegate—H. C. Atkinson, Macon

*Colquitt County Medical Society*

The Colquitt County Medical Society announces the following officers for 1946:

President—R. M. Joiner, Moultrie  
Vice-President—W. R. McGinty, Moultrie  
Secretary-Treasurer—A. G. Funderburk, Moultrie  
Delegate—J. B. Woodall, Moultrie  
Alternate Delegate—R. M. Joiner, Moultrie

*Coweta County Medical Society*

The Coweta County Medical Society announces the following officers for 1946:

President—W. H. Tanner, Newnan  
Secretary-Treasurer—M. F. Cochran, Newnan

*Elbert County Medical Society*

The Elbert County Medical Society announces the following officers for 1946:

President—G. A. Ward, Elberton  
Vice-President—W. A. Johnson, Elberton  
Secretary-Treasurer—A. S. Johnson, Elberton  
Delegate—D. N. Thompson, Elberton



*Emanuel County Medical Society*

The Emanuel County Medical Society announces the following officers for 1946:

President—D. D. Smith, Swainsboro  
 Secretary-Treasurer—C. E. Powell, Swainsboro  
 Delegate—D. D. Smith, Swainsboro  
 Alternate Delegate—C. E. Powell, Swainsboro

*Forsyth County Medical Society*

The Forsyth County Medical Society announces the following officers for 1946:

President—Rupert H. Bramblett, Jr., Rt. 3, Cumming  
 Vice-President—Marcus Mashburn, Sr., Cumming  
 Secretary-Treasurer—Courtney C. Brooks, Cumming  
 Delegate—Marcus Mashburn, Sr., Cumming  
 Alternate Delegate—Courtney C. Brooks, Cumming

*Franklin County Medical Society*

The Franklin County Medical Society announces the following officers for 1946:

President—Stewart D. Brown, Royston  
 Vice-President—E. T. Pool, Lavonia  
 Secretary-Treasurer—B. T. Smith, Carnesville  
 Delegate—E. T. Pool, Lavonia

*Glynn County Medical Society*

The Glynn County Medical Society announces the following officers for 1946:

President—H. M. Coe, Brunswick  
 Vice-President—S. P. McDaniel, Brunswick  
 Secretary-Treasurer—Thomas W. Collier, Brunswick  
 Delegate—I. G. Towson, Sea Island  
 Alternate Delegate—S. P. McDaniel, Brunswick

*Crisp County Medical Society*

The Crisp County Medical Society announces the following officers for 1946:

President—H. J. Williams, Cordele  
 Vice-President—Charles Adams, Cordele  
 Secretary-Treasurer—A. J. Whelchel, Cordele  
 Delegate—P. L. Williams, Cordele

*Floyd County Medical Society*

The Floyd County Medical Society announces the following officers for 1946:

President—Robert F. Norton, Rome  
 Vice-President—Ralph B. McCord, Rome  
 Secretary-Treasurer—Lee H. Battle, Jr., Rome  
 Delegate—J. T. McCall, Sr., Rome  
 Alternate Delegate—Robert M. Harbin, Jr., Rome

*Habersham County Medical Society*

The Habersham County Medical Society announces the following officers for 1946:

President—J. B. Jackson, Clarkesville  
 Vice-President—Bruce Swain, Clarkesville  
 Secretary-Treasurer—T. H. Brabson, Cornelia  
 Delegate—D. H. Garrison, Clarkesville  
 Alternate Delegate—O. N. Harden, Cornelia

*Hall County Medical Society*

The Hall County Medical Society announces the following officers for 1946:

President—Jesse L. Meeks, Gainesville

Vice-President—W. R. Garner, Gainesville  
 Secretary-Treasurer—H. H. Lancaster, New Holland  
 Delegate—C. D. Whelchel, Gainesville  
 Alternate Delegate—B. B. Davis, Gainesville

*Haralson County Medical Society*

The Haralson County Medical Society announces the following officers for 1946:

President—O. D. King, Bremen  
 Secretary-Treasurer—C. H. Allen, Bremen  
 Delegate—C. H. Allen, Bremen

*Hart County Medical Society*

The Hart County Medical Society announces the following officers for 1946:

President—A. O. Meredith, Hartwell  
 Secretary-Treasurer—G. T. Harper, Rt. 1, Dewy Rose

*Henry County Medical Society*

The Henry County Medical Society announces the following officers for 1946:

President—R. V. Brandon, McDonough  
 Secretary-Treasurer—A. W. Carter, Jr., McDonough  
 Delegate—H. C. Ellis, McDonough

*Jasper County Medical Society*

The Jasper County Medical Society announces the following officers for 1946:

President—L. Y. Pittard, Monticello  
 Vice-President—F. S. Belcher, Monticello  
 Secretary-Treasurer—E. M. Lancaster, Shady Dale  
 Delegate—F. S. Belcher, Monticello

*Jenkins County Medical Society*

The Jenkins County Medical Society announces the following officers for 1946:

President—H. G. Lee, Millen  
 Vice-President—Cleveland Thompson, Millen  
 Secretary-Treasurer—Q. A. Mulkey, Millen  
 Delegate—Katherine Rawls, Sylvania

*South Georgia Medical Society*

The South Georgia Medical Society—Berrien, Clinch, Cook, Echols, Lanier and Lowndes—announces the following officers for 1946:

President—R. L. Hutchinson, Adel  
 Vice-President—T. H. Smith, Valdosta  
 Secretary-Treasurer—Marion E. Farbar, Valdosta  
 Delegate—E. F. Thompson, Valdosta  
 Alternate Delegate—G. T. Crozier, Valdosta

*Macon County Medical Society*

The Macon County Medical Society announces the following officer for 1946:

Secretary-Treasurer—Thomas M. Adams, Montezuma

*Meriwether-Harris Counties Medical Society*

The Meriwether-Harris Counties Medical Society announces the following officers for 1946:

President—V. H. Bennett, Gay  
 Vice-President—J. A. Johnson, Manchester  
 Secretary-Treasurer—R. B. Gilbert, Greenville  
 Delegate—R. B. Gilbert, Greenville  
 Alternate Delegate—J. A. Johnson, Manchester



*Monroe County Medical Society*

The Monroe County Medical Society announces the following officers for 1946:

President—W. J. Smith, Forsyth

Secretary-Treasurer—G. H. Alexander, Forsyth

*Polk County Medical Society*

The Polk County Medical Society announces the following officers for 1946:

President—John M. McGehee, Cedartown

Vice-President—Raymond F. Spanjer, Cedartown

Secretary-Treasurer—Cecil B. Elliott, Cedartown

Delegate—O. R. Styles, Cedartown

Alternate Delegate—P. O. Chaudron, Cedartown

*Randolph-Terrell Counties Medical Society*

The Randolph-Terrell Counties Medical Society announces the following officers for 1946:

President—Robert B. Martin, III, Cuthbert

Vice-President—Charles R. Smith, Dawson

Secretary-Treasurer—W. G. Elliott, Cuthbert

Delegate—W. G. Elliott, Cuthbert

Alternate Delegate—J. W. Humber, Lumpkin  
(Deceased)

*Richmond County Medical Society*

The Richmond County Medical Society announces the following officers for 1946:

President—Perry P. Volpito, Augusta

Vice-President—D. R. Thomas, Augusta

Secretary-Treasurer—H. P. Harrell, Augusta

Delegate—R. C. McGehee, Augusta

Alternate Delegate—D. R. Thomas, Augusta

*Spalding County Medical Society*

The Spalding County Medical Society announces the following officers for 1946:

President—Thomas J. Floyd, Jr., Griffin

Vice-President—T. G. Smaha, Griffin

Secretary-Treasurer—T. O. Vinson, Griffin

Delegate—T. G. Smaha, Griffin

Alternate Delegate—Thomas J. Floyd, Jr., Griffin

*Tattnall County Medical Society*

The Tattnall County Medical Society announces the following officers for 1946:

President—J. C. Collins, Collins

Vice-President—L. R. Jelks, Reidsville

Secretary-Treasurer—J. M. Hughes, Glennville

Delegate—L. V. Strickland, Cobbtown

*Thomas County Medical Society*

The Thomas County Medical Society announces the following officers for 1946:

President—George R. Dillinger, Thomasville

Vice-President—John Mobley, Thomasville

Secretary-Treasurer—Mary J. Erickson, Thomasville

*Tift County Medical Society*

The Tift County Medical Society announces the following officers for 1946:

President—Carlton A. Fleming, Tifton

Vice-President—Charles E. Zimmerman, Tifton

Secretary-Treasurer—C. S. Pittman, Tifton

Delegate—W. H. Hendricks, Tifton

*Walker-Catoosa-Dade Counties Medical Society*

The Walker-Catoosa-Dade Counties Medical Society announces the following officers for 1946:

President—Fred H. Simonton, Chickamauga

Vice-President—C. W. Stephenson, Ringgold

Secretary-Treasurer—Frank L. O'Connor, Rossville

Delegate—Fred H. Simonton, Chickamauga

Alternate Delegate—Frank L. O'Connor, Rossville

*Ware County Medical Society*

The Ware County Medical Society announces the following officers for 1946:

President—T. J. Ferrell, Waycross

Vice-President—Lewis H. Oden, Jr., Blackshear

Secretary-Treasurer—L. W. Pierce, Waycross

Delegate—W. F. Reavis, Waycross

Alternate Delegate—C. A. Witmer, Waycross

*Washington County Medical Society*

The Washington County Medical Society announces the following officers for 1946:

President—O. D. Lennard, Sandersville

Vice-President—N. J. Newsom, Sandersville

Secretary-Treasurer—William Rawlings, Sandersville

Delegate—E. G. Newsome, Sandersville

Alternate Delegate—R. L. Taylor, Davisboro

*Wayne County Medical Society*

The Wayne County Medical Society announces the following officers for 1946:

President—Thomas G. Ritch, Jesup

Vice-President—J. Lawton Tyre, Screven

Secretary-Treasurer—James W. Yeomans, Jesup

Delegate—J. A. Leaphart, Jesup

Alternate Delegate—Una F. Ritch

*Whitfield County Medical Society*

The Whitfield County Medical Society announces the following officers for 1946:

President—Fred B. Ragland, Dalton

Vice-President—D. L. Wood, Dalton

Secretary-Treasurer—H. J. Ault, Dalton

Delegate—Truman Whitfield, Dalton

*Wilkes County Medical Society*

The Wilkes County Medical Society announces the following officers for 1946:

President—T. C. Nash, Pilomath

Vice-President—C. E. Wills, Washington

Secretary-Treasurer—R. G. Stephens, Washington

Delegate—H. L. Cheves, Union Point

*Upton County Medical Society*

The Upton County Medical Society announces the following officers for 1946:

President—T. A. Sappington, Thomaston

Vice-President—James A. Woodall, Thomaston

Secretary-Treasurer—John D. Blackburn, Thomaston

Delegate—R. L. Carter, Thomaston

Alternate Delegate—J. E. Garner, Thomaston

*Mitchell County Medical Society*

The Mitchell County Medical Society announces the following officers for 1946:

President—C. L. Howard, Pelham  
 Vice-President—M. W. Williams, Camilla  
 Secretary-Treasurer—D. P. Belcher, Pelham  
 Delegate—J. C. Brim, Pelham  
 Alternate Delegate—M. W. Williams, Camilla

## NEWS ITEMS

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the dining room, February 14. Three interesting cases were presented for discussion: "Tuberculous Meningitis," "Peripheral Vascular Disease," and "Retroperitoneal Sarcoma in a Child."

Dr. J. Mason Baird, Atlanta, having returned from active service with the United States Navy Medical Corps, announces the re-opening of his office, 511 Medical Arts Building, Atlanta. Associated with Dr. Grady E. Clay.

Dr. Samuel W. Perry, Atlanta, announces the association of Dr. H. Bagley Benson with him in the practice of pediatrics, 719 Doctors Building, Atlanta.

The Wilkes County Medical Society held its first meeting of the year on January 3, 1946. Officers are: President, Dr. T. G. Nash; Vice-President, Dr. C. E. Wills; Secretary-Treasurer, Dr. R. G. Stephens; Board of Censors, Dr. C. E. Wills and Dr. H. L. Cheves. Two new members were received into the society and were given a cordial welcome. They are Dr. Roy J. Johnson, Jr., of Thomson, and Dr. M. C. Adair, of Washington.

Dr. John D. Campbell, Atlanta, announces the opening of offices for the practice of psychiatry at 26 Linden Avenue, N.E., Atlanta.

Dr. Nathan I. Gershon, Atlanta, recently discharged from the United States Navy, announces the opening of his office at 26 Linden Avenue, N. E., Atlanta. Practice limited to eye, ear, nose and throat.

Dr. Wadley R. Glenn, Atlanta, announces his association with Dr. L. C. Fischer, Crawford W. Long Memorial Hospital, Atlanta.

Dr. Eugene L. Griffin, Atlanta, announces the opening of his office for the practice of obstetrics and gynecology in association with Dr. Lawrence P. Matthews, 1282 South Oxford Road, N. E., Atlanta.

Dr. Aubrey L. Huskey, Atlanta, announces his return from military service and resumption of ear, nose and throat practice with Dr. Calhoun McDougall, 703 Medical Arts Building, Atlanta.

Dr. James T. King, Atlanta, after five years with the United States Army Air Forces, announces his association with Dr. Leon E. Brawner, 803 Medical Arts Building, Atlanta. Diseases of the ear, nose and throat.

Dr. Bruce Logue, Atlanta, announces the opening of his office Emory University Hospital, Atlanta. Practice limited to cardiology.

Dr. Robert W. McAllister, Macon, announces the opening of his office in the Doctors Building, 700 Spring Street, Macon. Practice limited to urology.

The Bartow County Medical Society met at the office of Dr. S. M. Howell January 3, 1946 officers are: Dr. Hugh S. McGowan, president; Dr. A. L. Horton, secretary-treasurer, and Dr. William B. Quillian, Jr., censor for a three-year term.

Dr. C. M. Adair, Washington, recently discharged from the Medical Corps, U. S. Army, announces his association with Dr. A. W. Simpson, Dr. C. E. Wills, and Dr. Addison Simpson, Jr., Washington.

Dr. Sanford E. Ayers, Toccoa, recently resigned his commission as a commander in the Navy to resume his position as medical director for the La Tourneau Company, Toccoa. He will also engage in private practice.

Dr. Allen W. Coward, Savannah, recently discharged from the United States Army, announces the opening of offices at 17 Jones Street, East, Savannah.

Dr. Roy Denny, formerly of Alma, announces his association with Dr. H. L. Barker, Huff Building, Carrollton.

Dr. Ivylyn Girardeau, a native of Thomaston who spent several years in India as a missionary, announces the opening of her office at 204 East Gordon Street, Thomaston. Practice limited to pediatrics.

Dr. Willard R. Golsan, Macon, recently discharged from the Army Medical Corps, has resumed his practice as urologist at Macon.

Dr. Lynn M. Huie, Monroe, recently discharged after more than three years' service in the Army Medical Corps, has resumed his practice at Monroe.

Dr. Edward Johnson, Manchester, recently discharged from military service, announces his association with his father, Dr. J. A. Johnson, in the practice of medicine at Manchester.

Dr. Harold W. Long, Eastman, recently discharged from the Medical Corps of the U. S. Army, has resumed his practice as physician and surgeon at Eastman.

Dr. James D. Manget, Jr., Atlanta, after forty-five months active duty in the Army Medical Corps, is again associated with his father, Dr. J. D. Manget, Sr., 118 Forrest Avenue, N. E., Atlanta, in the practice of medicine and surgery.

Dr. Charles E. McArthur, Cordele, recently discharged from the Army Medical Corps, announces the re-opening of his office at Cordele.

Dr. R. C. Pendergrass, Americus, for more than three years a member of the U. S. Army Medical Corps, has received his discharge and resumed the practice of medicine at Americus.

Dr. John H. Pinholster, Savannah, recently discharged from the U. S. Navy, announces the re-opening of his office at 4 West Liberty Street, Savannah, for the practice of medicine.

Dr. Guy V. Rice, Albany, recently returned from two years service overseas with the Army Medical Corps, has rejoined the Georgia Department of Public Health as assistant director of the division of Maternal and Child Health with headquarters at Albany.

Dr. Everett S. Sanderson, Augusta, who has accepted an assignment for one year's work in China with the United Nations Relief and Rehabilitation Administration, has been granted a leave of absence from the University of Georgia School of Medicine in order that he may go to China.

Dr. Robert Daniel Walter, Calhoun, has been released to inactive duty in the Naval Reserve, and has resumed his practice of medicine at Johnston-Hall Hospital, Calhoun.

Dr. W. D. Willcox, Fitzgerald, recently discharged from the U. S. Navy, announces his association with Dr. Francis Ward, First National Bank Building, Fitzgerald, for the practice of medicine.

Dr. D. Lloyd Wood, Dalton, recently discharged from the Army Medical Corps, has resumed the practice of medicine at 200 King Street, Dalton.

The Southeastern Allergy Association will hold its first meeting at the Atlanta Biltmore Hotel, Atlanta, on Saturday, March 30, and Sunday, March 31. Business meeting will begin at 10 A. M. Saturday, with Dr. Hal McCluney Davison, Atlanta, presiding. Luncheon at noon will be followed by a scientific session with the following program: 1. "Contact Allergy," Dr. Oscar Swineford; 2. "Headaches," Dr. William Crowe; 3. "Preparation of Extracts," Dr. Edna Pennington. Banquet Saturday night. Sunday session, 10 A. M. will include: 1. "The Relationship Between Immediate and Delayed Skin Reactions," Dr. John Jacobs; 2. "Allergy in Childhood," Dr. Susan Dees; 3. "Allergic Rhinitis," Dr. Randolph Graham. This meeting is open to everyone interested in allergy regardless of the type practice one has. Notify the secretary, Dr. Katherine Baylis MacInnis, 1515 Bull St., Columbia, S. C. if you wish your name added to mailing list; also if you plan to attend the first meeting notify the secretary in order that there may be some idea of the number planning to attend this meeting. Make hotel reservations direct with the Atlanta Biltmore Hotel, Atlanta, and mention the Southeastern Allergy Association.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, February 7. Program: Case Report—"Calcified Myocardium," Dr. L. Minor Blackford; Clinical talk—"Surgical Treatment of Carcinoma of Esophagus," Dr. Osler Abbott; Paper—"Six Medical Myths of the Tropics," Dr. Herbert Alden. "Proposals of the Establishment of a Medical Center," Dr. J. E. Paullin.

Dr. Alton V. Hallum, Atlanta, was recently elected to membership in the American Ophthalmological Society. His thesis "The Retinal Arterioles in the Hypertensions During Pregnancy" will be published in the Archives of Ophthalmology.

Dr. Laurence B. Dunn, Savannah, recently released from the Army Medical Corps, will resume the practice of medicine at Savannah.

The Richmond County Medical Society meeting was held at the University Hospital, Augusta, January 17. Program: "Post-War Health Program," Dr. Rufus Payne, superintendent of the Georgia Tuberculosis Sanatorium, Alto, who was introduced by Dr. Abe Davis, Richmond County Health Commissioner, Augusta.

Dr. J. W. Simmons, Brunswick, recently joined Dr. C. F. Holton, chief surgeon of the Central of Georgia Railroad, Savannah, and travelled from Savannah to Atlanta in Dr. Holton's private car, to be guests at the annual banquet of the Atlanta Claim Association, January 19.

Dr. W. R. Richards, Greensboro, has resigned as Commissioner of Public Health for Greene County. Dr. Richards came to Greensboro from Calhoun and assumed charge of the County Health Department, which has done excellent work under his direction.

Dr. James S. Peters, Jr., Nashville, recently discharged from the U. S. Army Medical Corps, has resumed the practice of medicine at Nashville.

Dr. R. B. Martin, III, Cuthbert, recently returned from the Pacific Theater of War, after more than four years' service in army hospitals, has resumed his connection with Patterson Hospital, Cuthbert.

The C. V. Mosby Company, St. Louis, Mo., takes pleasure in announcing the election of Dr. Claude Wood to the office of vice-president, and his appointment as editorial consultant.

The annual banquet to the medical and surgical staff by the Georgia Baptist Hospital, Atlanta, was held in the Nurses' Home Dining Room, February 19. Program: Dr. Louie D. Newton, presiding; Invocation, Dr. Dick H. Hall, Jr., pastor First Baptist Church, Decatur; Report for Secretary for 1945, Dr. L. H. Muse; Report of Superintendent; Comments by Retiring President, Dr. B. L. Shackelford; Address, Dr. Monroe F. Swilley, Jr., pastor of Second-Ponce de Leon Baptist Church, Atlanta; Announcement of Staff Appointments for 1946-47, Dr. James W. Merritt, Secretary Hospital Commission; Comment by Incoming President; Announcements, and Adjournment.

Dr. Robert T. Jones, III, Canton, recently released after more than two years' service in the U. S. Army Medical Corps, has resumed his duties as general practitioner and surgeon at Coker Hospital, Canton.

Emory University School of Medicine, Atlanta, announces the following faculty members have returned from military service: Dr. Daniel C. Elkin, professor of surgery; Dr. Elbert B. Agnor, assistant in medicine; Dr. Herbert S. Allen, assistant professor of dermatology; Dr. William B. Armstrong, instructor in clinical otorhinolaryngology; Dr. M. K. Bailey, professor of urology; Dr. H. Bagley Benson, assistant in pediatrics; Dr. Everett L. Bishop, associate professor of pathology



(neoplastic diseases); Dr. L. M. Blackford, associate in medicine; Dr. F. K. Boland, Jr., instructor in surgery; Dr. Joseph Boland, instructor in orthopedic surgery; Dr. B. Russell Burke, associate in clinical otorhinolaryngology; Dr. T. Sterling Clairborne, instructor in medicine; Dr. Emmett D. Colvin, assistant professor of obstetrics and gynecology; Dr. John B. Cross, associate in obstetrics and gynecology; Dr. Mark S. Dougherty, instructor in medicine; Dr. Charles E. Dowman, assistant in neurosurgery; Dr. Charles A. Eberhart, assistant in urology; Dr. Ira A. Ferguson, assistant professor of clinical surgery; Dr. Wadley R. Glenn, assistant in surgery; Dr. C. Stedman Glisson, assistant in obstetrics and gynecology; Dr. Wm. H. Grimes, assistant in obstetrics and gynecology; Dr. Hugh Hailey, instructor in dermatology; Dr. A. Worth Hobby, assistant in medicine; Dr. Byron J. Hoffman, instructor in pathology; Dr. J. Harry Lange, assistant in pediatrics; Dr. Albert O. Linch, associate in surgery; Dr. R. Bruce Logue, instructor in medicine; Dr. J. D. Martin, Jr., assistant professor of surgery; Dr. J. Merrell Monfort, associate in medicine; Dr. Hugh G. Mosley, instructor in obstetrics and gynecology; Dr. Gene Nardin, assistant in medicine; Dr. Julian G. Riley, instructor in surgery; Dr. Cyrus W. Strickler, Jr., instructor in medicine; Dr. Wm. H. Trimble, assistant in medicine; Dr. James I. Weinberg, assistant in medicine; Dr. Richard B. Wilson, associate professor in neurology; Dr. Bernard P. Wolff, assistant in medicine; and Dr. Edward S. Wright, associate in clinical otorhinolaryngology.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, February 26. Program: Discussion of *The Socialization Trends* with other interested groups present (Dental—Law—Druggist—Real Estate—Insurance).

The University of Georgia School of Medicine Chapter of Alpha Omega Honor Medical Fraternity recently announced the election of the following new members:

Graduates of the school elected to membership on the basis of success in their profession, and for their contributions to the public welfare, are Dr. Guy G. Lunsford, Atlanta, Associate Director of the Georgia Department of Public Health; Dr. Herbert S. Alden, Atlanta, dermatologist; Dr. William H. Kelley, Charleston, S. C., Professor of Medicine, Medical College of the State of South Carolina; Dr. Rufus F. Payne, Alto, Superintendent of the Georgia State Tuberculosis Sanatorium, and Dr. Stewart Hart Auerbach, Augusta, Associate Professor of Pathology, University of Georgia School of Medicine.

Students elected to membership on the basis of scholarship are: from the senior class, Herman Delancy, Cartersville; Lawton Quinby Hair, Augusta; Lamar B. Peacock, Albany; Edgar DeWitt Shanks, Jr., Atlanta, and Walter Allen Sikes, Augusta; from the junior class, Willard Palmer Carson, Dalton; Harold Winfield Goldin, Rockmart, and Roy Belmont Hargrove, Jr., Waynesboro.

The Fifth District Medical Society held its semi-annual scientific meeting at the Academy of Medicine,

Atlanta, February 21. Scientific session: "Address," Dr. Cleveland Thompson, Millen, President, Medical Association of Georgia; "Wound Healing," Dr. Ira A. Ferguson, Atlanta; "Hepatitis," Dr. L. Minor Blackford, Atlanta; "Rheumatic Fever," Dr. T. Sterling Clairborne, Atlanta. Officers: Dr. Homer Allen, president, Decatur; Dr. E. A. Bancker, vice-president, Atlanta; Dr. George A. Williams, secretary-treasurer, Atlanta; Dr. Marion C. Pruitt, councilor, Atlanta; and Dr. Spencer A. Kirkland, vice-councilor, Atlanta.

Officers of the Woman's Auxiliary to the Fifth District Medical Society: Mrs. Shelley C. Davis, president, Atlanta; Mrs. Frank K. Boland, Sr., vice-president, Atlanta; and Mrs. Harvey Hamff, secretary, Atlanta.

Dr. Harry T. Harper, Jr., associate professor of medicine, University of Georgia School of Medicine, Augusta, and Dr. Marion W. Mathews, assistant professor of medicine, University of Georgia School of Medicine, Augusta, announce the opening of offices at 910 Marion Building, Augusta, for the practice of internal medicine and cardiology.

The Bibb County Medical Society held its monthly meeting at Ridley Hall, Macon, February 5. Dr. R. W. McAllister was in charge of the program.

#### OBITUARY

*Dr. Jesse Weathers Humber*, aged 56, prominent Lumpkin physician, died at Patterson Hospital, Cuthbert, Jan. 15, 1946. Dr. Humber was born in Stewart County, the son of Mrs. Fannie Weathers Humber and the late Mr. C. N. Humber. He graduated from the Emory University School of Medicine, Atlanta, in 1915. Dr. Humber was always square, ready to give or to lend. He held in the lives of the people of his community the place of love, loyalty and highest respect. He was a member of the Randolph-Terrell Counties Medical Society, the Medical Association of Georgia, and the American Medical Association. Surviving are his wife, Mrs. Lois Cox Humber; a son, Weathers Humber, Tifton; a daughter, Mrs. W. C. Layer, Montgomery; his mother, Mrs. Fannie Weathers Humber, Lumpkin; one grandchild, Tommy Humber; one sister, and five brothers. Funeral services were held at the Lumpkin Methodist Church with Rev. C. A. Morrison, pastor, officiating, assisted by Rev. J. L. Brown and Rev. C. L. Wall. Burial was in Northside Cemetery, Lumpkin.

*Dr. James Daniel Nall*, aged 64, retired Atlanta physician, died at a private hospital Jan. 24, 1946. Dr. Nall was a native of Butler County, Alabama, and was graduated from the University of the South Medical Department, Sewanee, Tenn., in 1907. He had practiced medicine in Villa Rica and Atlanta for 40 years. He was on the board of the Crawford W. Long Memorial Hospital before his retirement. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, and the First Methodist Church. He was a Mason and a member of I. O. O. F. Survivors are his wife, the former Miss Minnie Elizabeth Walton, of Nashville; three sons, Lt. A. Walton Nall, now stationed in New York; Wil-

bur B. Nall, Atlanta; Ph.M. 2-c William E. Nall, stationed in San Francisco; five sisters, two brothers, and several grandchildren. Funeral services were held at Spring Hill, with the Rev. J. W. Veatch officiating. Burial was in West View Cemetery, Atlanta.

*Dr. George Henry Noble*, aged 56, of St. Augustine, Fla., and Atlanta, died at St. Augustine, Feb. 12, 1946. He was the son of the late Dr. and Mrs. George H. Noble of Atlanta, and was graduated from Columbia University College of Physicians and Surgeons, New York, in 1917. Dr. Noble practiced medicine in Atlanta for the past 30 years, but recently moved to St. Augustine. Survivors include his wife; three daughters, Mrs. J. T. Cosby, Ft. Worth; Mrs. W. H. Naff, Atlanta, and Miss Mary Ila Noble, St. Augustine; two sons, George H. Noble, III, and Paul Avery Noble; a sister, Mrs. Victor Moore. Funeral services were held at the Cathedral of St. Philip, with the Rev. Matthew M. Warren officiating. Burial was in West View Cemetery, Atlanta.

*Dr. Samuel T. R. Revell*, aged 65, died at his residence, Louisville, Jan. 13, 1946. He was born in Anne Arundel County, Maryland, the oldest son of the late Dr. and Mrs. Henry May Revell. Dr. Revell was a graduate of the University of Maryland School of Medicine, Baltimore, in 1905. After graduation he became instructor of osteology at the University of Maryland and spent one year in the tuberculosis section of Johns Hopkins, before coming to Louisville to do general practice in 1907. Dr. Revell was interested in the advancement of medical science and was allied with every health movement in his section and gave untiringly to all philanthropic activities.

He was past president of the Jefferson County Medical Society; past president of the Sixth District Medical Society; past first vice-president of the Medical Association of Georgia; and a member of the American Medical Association. He was also a member of the Kiwanis Club; a Mason; a veteran of World War I; and a member of the Associate Reformed Presbyterian Church. He is survived by his wife, Mrs. Lettie Jones Revell; two sons, Dr. Samuel T. R. Revell, Jr., Baltimore, Md.; and Lt. Comdr. Walter J. Revell, M.C., U.S.N.R., two brothers, and two sisters. Funeral services were held at the Presbyterian Church, with Dr. M. R. Plaxco officiating. Burial was in Louisville Cemetery, Louisville.

*Dr. Holt Darden*, aged 47, Blakely physician, died at his home Jan. 30, 1946. He graduated from the Emory University School of Medicine, Atlanta, in 1925. He was a member of the Blakely Methodist Church. Survivors include his wife, Mrs. Irene Darden; a son, Holt Darden, Jr. of the U. S. Navy, Sampson, N. Y.; and a brother, Fred H. Darden, Blakely. Funeral services were held at the Minter Funeral Home, with Rev. Anthony Hearn officiating, assisted by Rev. J. Alton Davis. Burial was in the Blakely Cemetery, Blakely.

*Dr. William Tarlton McCurdy*, aged 70, Stone Mountain, one of DeKalb County's best-known physicians,

having practiced medicine for nearly 50 years, died at his home Feb. 13, 1946. Dr. McCurdy graduated from Emory University School of Medicine, Atlanta, in 1897. He was a member of the DeKalb County Medical Society, the Medical Association of Georgia, the American Medical Association, and the Stone Mountain Baptist Church. He was a Mason and a Shriner. His deceased wife was Mrs. Mamie Tuggle McCurdy. Survivors include four daughters, Mrs. Mark Britt, Jr., Mrs. Rufus Evans, Miss Mary McCurdy, and Miss Myrtle McCurdy, all of Stone Mountain; three sons, Dr. Willis T. McCurdy and John Steve McCurdy, both of Stone Mountain, and Dr. Jim McCurdy, Thomaston; and five grandchildren. Funeral services were held at the Stone Mountain Baptist Church, Stone Mountain.

### TUBERCULOSIS

Tuberculosis is intimately linked with nutrition, both because the disease is common under famine conditions, and because an individual's lowered resistance is connected with appetite disorders, and wrong dietetic habits. One-third of tuberculosis people cannot obtain a proper diet on account of inadequate income. Better nutrition for all will enable the community to shoulder the burden of its tuberculosis, and gradually diminish the weight of that load.—NAPT Bull., England, June, 1945.

Most of the permanent value of a tuberculosis survey program depends on a thorough follow-up of definite and suspicious cases in regular diagnostic clinics where the history, physical, laboratory and x-ray findings permit accurate evaluation of the status of the patient's disease.—Cattaraugus Co. (N. Y.) Health Department.

Extreme care must be exercised to ensure that no cases be stigmatized with the diagnosis of tuberculosis or tuberculosis suspect on one roentgenographic observation. Careful clinical history and physical examination are still required for diagnosis.—Carelton B. Peirce, M.D., et al. Am. Rev. Tbc., July, 1945.

### HOTEL RESERVATIONS FOR MACON SESSION

Listed below are Macon's hotels. It is important that each member of the Association secure hotel accommodations for the Ninety-Sixth Annual Session of the Association. Remember, the meetings of the House of Delegates begin at two o'clock Tuesday afternoon, May 7; the scientific program at eight-thirty o'clock Wednesday morning, May 8, and continues until noon Friday, May 10.

#### Hotels

Hotel Dempsey, Headquarters	Hotel Lanier
Central Hotel	Southland Hotel
Georgian Hotel	Milner Hotel



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### GRANULOMA INGUINALE

#### *A Study of 200 Cases*

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*Atlanta*

Granuloma inguinale is a tropical disease endemic in British Guinea, Africa, India, Northern Australia, South China, and the West Indies; sporadic in Ceylon, Malaya, the East Indies, and South America; rare in the North, more common in the South to which it was brought by slaves and sailors of the high seas. It is practically confined to the Negro race and dark-skinned people. During the past twenty years this disease has intrigued me. It may be defined as a chronic granular infectious disease affecting the skin or quasi mucous membrane, primarily of the genital regions where the granulations, hypertrophic and keloid scars accumulate, in which the Donovan body may be found. Granuloma inguinale is variously termed granuloma inguinale venereum, granuloma venereum, and *esthiomene de la vulve*. It was first described by McLeod<sup>1</sup> in 1882, then Donovan<sup>2</sup> in 1905 described the etiologic agent.

Of the 200 cases in this study, 175 were treated at the Venereal Disease Clinic of the City of Atlanta, known as Atlanta Health Center No. 1, located at 11 Hunter Street, S. W. The remaining 25 were studied at the Out-Patient Clinics of the Emory Unit of Grady Hospital, Atlanta. I personally observed, diagnosed, and treated all cases comprising this series. There were 128 males and 72 females. Their ages varied from 15 to 51 years, the average being between 25 and 30 years. This is a disease of relatively young individuals. Three deaths occurred in this series; anemia due to chronic blood loss was the pri-

mary cause. The time interval in which the patients were observed was from January 1, 1942 to March 1, 1944.

The frequency of granuloma inguinale is made evident by the incidence of five venereal diseases in order of frequency admitted to the Atlanta Health Center No. 1 Venereal Disease Center, during the year 1943: Syphilis, 4,481 cases; gonorrhea, 959 cases; chancroid, 287 cases; granuloma inguinale, 94 cases; lymphogranuloma venereum (also termed lymphopathia), 69 cases. The total number of cases was 5,890. All 94 cases of granuloma inguinale were in Negroes. No whites with the disease have ever been admitted to this clinic. While not now in alarming frequency, granuloma inguinale presents aspects which demand consideration and action.

About 20 of the cases in my series had been married. Their marital status, however, changed at intervals and reliable data cannot be given other than that the majority were single. Many lost their mates as the lesions progressed. A great number continued intercourse despite their disease.

Little has been learned relative to the contacts of these patients. Many contacts were examined, but none showed evidence of the disease. Only two Army contact cases were examined. No new information came from these examinations, inasmuch as the suspected individuals did not have the disease. Of those few individuals who were married at the time of admission, the spouse did not have granuloma inguinale; some had other diseases. Only one case was found in which both man and wife had the disease. They likewise had in addition syphilis and lymphopathia venereum.

To condense the problem of epidemiology I can state that from the study of these 200 cases, and of all other cases seen in

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my lifetime, I have not been able to answer the question, "From whom was the disease caught?" The experimental work of Greenblatt, Pund, Torpin<sup>3</sup>, Dienst<sup>4</sup>, Carter<sup>5</sup>, Jones, and Thomas<sup>6</sup>, showed the incubation period to be from two to twelve weeks. This indefinite period of incubation is in keeping with the inability to find the right contact.

In this consideration one cannot help but raise the question of the nature of the Donovan body, the causative agent. Castellani<sup>7</sup>, Pund and Dienst<sup>4</sup> consider the organism protozoan; Aragao and Vianna<sup>8</sup>, a separate genus of schizomycetes. Other workers, as Flu<sup>9</sup>, believe it to be chlamydozoon; Siebert<sup>10</sup> says an encapsulated diplococcus; Markham and Carter<sup>11</sup> concluded that it is a herpetomonas or trypanosome. Donovan<sup>12</sup> believed granuloma inguinale to be caused by an epithelial cell parasite belonging to the gregarian order of sporozoa<sup>13</sup>. I believe the organism is a protozoa because all organisms cultured to present date fail to reproduce the disease when transferred to other humans. Anderson<sup>14</sup> in 1943 cultured a bipolar body in egg yolk sacs of chick embryos five to six days old, but these organisms failed to grow on humans. Pund, Greenblatt, Torpin, Sanderson, Dienst, Carter, Jones, Thomas, and McIntosh<sup>15</sup> were unable to fulfill Koch's law with such artificially grown organisms.

If there is any one point that is worth stressing to the social worker as well as to the physician, it is that in none of the 200 cases was granuloma inguinale found occurring alone. All victims had or formerly had at least one other venereal disease, exclusive of gonorrhea, and most of them had had two, three, and even four venereal diseases. It has been noted in the contacts, many of whom had repeated exposures, that they had never had chancroid, syphilis, or lymphopathia venereum, all three of which produce moderate to severe fibrosis or damage to the pudenda and pelvic lymph channels and glands. Freedom from such sclerotic changes allows a freedom of, or immunity against, the invasion of the Donovan body. In a large number of our series, one could observe scars of former buboes of chancroid, lymphopathia or find long

standing, untreated syphilis. Such lymphatic tissue insult produces a patient who is a good candidate for granuloma inguinale. One might argue against this postulate in citing one infant<sup>16</sup> reported to have been infected by its granulomatous mother and of several two to four year old South Pacific children who developed the disease. Congenital syphilis could explain the cases.

Initial lesions in all males developed on the penis, whereas the vulvar lesions were primary in the female. Extension by continuity to the penile shaft or scrotum and subsequently to the groin or anal regions followed. Metastatic buboes were found in seven cases. These buboes were small, painless, and soon ruptured to infect the overlying skin. In the female extension was throughout the adjacent parts of the labia and thence downward to the perineum and in many cases to the anus. The vagina was invaded to a lesser degree. Most women develop swellings and hypertrophies of the labia and clitoris. As in the male, the granular areas are elevated so that the margins are raised above the surface of the surrounding skin. In only three cases were the eroded areas punched or ulcerated. As tissue is destroyed, the labia may become shredded and diminutive and finally the perineum and vagina destroyed rather than hypertrophied. This ulceration only occurs in women and is malignant, resistant to medication and ultimately fatal. One of the three patients died. Biopsy failed to show cancer. Noteworthy is the lack of stricture in the urinary meatus and the anus, although these areas are densely covered by granulations. The rectum and urethra are never involved. Rectal stricture spells lymphopathia venereum; urethral stricture more commonly means former gonorrhea infection. The cervix was not studied and no lesions were seen as reported by D'Aunoy and Von Haam,<sup>17</sup> Arnell and Potekin.<sup>18</sup>

After one is familiar with the disease, the clinical appearance is so characteristic that one can diagnose most of the cases by inspection alone. The raised, velvety red, granular, weeping, typically foul smelling lesion that bleeds easily and has persisted for weeks, months, or years readily tells

its own story. A point that clinicians should remember in differentiating granuloma inguinale from lymphopathia venereum (lymphogranuloma venereum) is that granuloma inguinale is primarily a disease of the skin, or very infrequently of modified mucous membranes. In every case that I have observed, at least some of the skin was involved. Lymphopathia venereum is a disease of lymph glands and lymph ducts, and it does not produce skin lesions unless one would consider the tiny button on the surface of a draining sinus, or the absence of skin over a bubo that has necrosed and sloughed away. Many fail to appreciate the coexistence of both diseases. Careful thinking and inspection will show that the skin primarily is not involved in lymphopathia.

In granuloma inguinale, embryonic lesions on the labia and prepuce do not have the reddened, velvety appearance that they will assume later, and, hence, resemble and can be easily mistaken for chancres. Lesions produced by the Ducrey bacillus have an undermining edge, whereas 99 per cent of so-called ulcers (lesions) of granuloma inguinale have elevated margins in addition to being painless. The stained smear will demonstrate the Ducrey bacillus. Dark field examination of the lesion will show treponema pallida in the early lesions of syphilis. If one will study the smears stained with Wright's stain as reported by Greenblatt and Pund<sup>19</sup> or Giemsa stain by Alexander and Shoch,<sup>20</sup> he should be able to recognize the Donovan body and the characteristic pathognomonic monocyte in at least 90 per cent of the untreated cases. Staining by the method of Dienst and Mortara<sup>21</sup> aids in the recognition of the Donovan body. If it cannot be identified from a small bit of tissue pinched off the lesion, then 1 per cent novocaine should be injected under the most reddened or active part of the lesion, a biopsy taken and an examination made by a pathologist capable of recognizing the Donovan body. It is pertinent that one point be stressed in the diagnosis: When a patient has been given six or more arsenical injections and six or more bismuth injections, or if he has had 15 to 20 grams of sulfathiazole in his treat-

ment for chancroid disease, he should be well of his ulcerative lesions. If he is not you may suspect that the diagnosis is in error and you should at once consider other diseases, among them granuloma inguinale.

First of all proper diagnosis must be made. One must recognize the occurrence of other venereal infections prior to and concomitant with granuloma inguinale. Treat the patient for chancroid, fusospirochetosis, monilia infection (lymphopathia), impetigo, trichomoniasis, or any systemic disease such as diabetes, syphilis, avitaminosis, anemia, tuberculosis, etc., if any of these are present. Topically used 1 per cent gentian violet, 5 per cent tartar emetic, 10 per cent silver nitrate, liquid phenol, sodium perborate, zinc peroxide powder, and finally, podophyllin in olive oil, as developed by Tomskey, Vickery, Gilbert, and Getzoff<sup>22</sup>, are helpful.

Some twenty-five different remedies were applied to various lesions during the past two years yielding no agent as effective as the above mentioned. Worthy of trial is the *per orum* use of ferrous sulphate, grains 15 daily, saturated solution of potassium iodide, drops 15 daily, powdered brewers' yeast, 1 to 4 tablespoons daily, sulfathiazole for coexisting diseases and elixir chlorocalcium compound, drachms 3 daily, to stop excessive bleeding. Antimony compounds, such as antimony potassium tartrate,<sup>23</sup> 1 per cent solution, 5 to 10 cc. by vein 1 to 3 times weekly, fuadin,<sup>24</sup> 5 cc. ampule twice weekly in buttock, anthiomaline or sodium antimony thioglycollate ampule twice weekly may be used up to the point of tolerance. After 4 to 15 injections many patients complain of aching bones and joints. They are switched to another compound. Usually they do not tolerate the next one very long. The drug is stopped and local remedies employed.

None of the remedies thus far given will completely cure granuloma inguinale. A few early cases seem to get well. Failure results in the majority. X-ray and radium do not cure the disease. At the present time the very best means of effecting an apparent cure must be found in the extirpation of the entire lesion by means of the knife or electrocoagulation with a Davis-



Bovie electrical unit. This is in accord with McLeod, Cole, Manson, Bahr, Conyers and Daniels, Robinson and Shelly.<sup>25</sup> Because of profuse bleeding after incision by the knife, the electrodesiccation and use of the coagulation current offer fewer difficulties. The financial difficulties and lack of beds arising from the prolonged hospitalization prevent the use of this method routinely in our clinic. Small lesions are removed at the clinic, but hospitalization and general anesthesia are required for extensive lesions. The base of the lesion is dense with fibrous tissue; this prevents infiltration of the novocaine, hence poor analgesia is obtained.

Granuloma inguinale is much more frequent among our Southern Negroes than is generally recognized. It is increasing every year. Health reports in general do not mention this disease. Georgia probably has from 1,000 to 4,000 cases. We admit that these cases are filthy, unwanted, and difficult to care for, but these cases are our problem. As has been shown in this discussion, while granuloma inguinale is not as highly communicable as the other venereal infections, its results are more serious. It leads to inescapable disabilities and fatalities. Local hospital facilities must be provided so that surgery or electro-surgery can be used. Only in this way may we stop the spread of this disease, prevent invalidism, and maintain our self-respect. Failure to assume responsibility in this matter may constitute a challenge to the very sovereignty of our State government and the right to the practice of medicine as we prefer it here in the South.

### Summary

1. Granuloma inguinale is a very chronic, infectious disease.
2. It is probably spread by cohabitation; the means of transference from host to host has not been proved.
3. Not all the factors involved in the epidemiology of the disease are known.
4. It is frequently confused with other venereal diseases. Former infections render the genital region more susceptible to the reception of the Donovan body, the causative agent.

5. Diagnosis from smears or small fragments is simple. The State Board of Health will give reliable reports on smears submitted.

6. All drugs thus far reported as curative agents fail to completely eradicate the Donovan body; biopsies of apparently cured lesions frequently reveal the Donovan body in a quiescent phase in deeper tissues.

7. Extirpation with a Davis-Bovie unit, under general anesthesia accompanied by injections of antimony salts, offers the best method of treatment at the present time.

8. Additional research and a more comprehensive understanding of this universally neglected disease should soon stimulate the interest of medical workers so that a real and permanent cure may finally be attained.

This article which deals with the diagnosis, treatment and significance of granuloma inguinale is the result of treatment and observation of cases at the City of Atlanta Venereal Disease Clinic and the Out-Patient Clinics of the Emory Unit of Grady Hospital, Atlanta. It contains 1,910 words.

I am indebted to Frances C. Lewis, Mary L. Preston, and other staff members of the Atlanta Health Center for their valuable assistance.

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## THE RECOGNITION OF URETEROPELVIC OBSTRUCTION

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### *General Consideration*

Hydronephrosis due to ureteropelvic obstruction is a complex disease in which several etiologic factors are involved and it is difficult to determine the exact cause of the ureteropelvic obstruction by pyelography. It is necessary to determine the exact etiologic factor before intelligent surgery can be instigated, since the type of operative treatment is dependent upon the cause of the obstruction. The diagnosis of hydronephrosis due to ureteropelvic obstruction is usually simple, being based upon a careful urologic survey, but with a few exceptions the determination of the cause of the ureteropelvic obstruction must be made at operation by careful examination of the ureteropelvic junction.

Fifty-one cases of ureteropelvic obstruction in otherwise healthy male soldiers have been seen at an army general hospital and are classified according to etiology, and reported in this paper.

### *Causes*

There are several causes of ureteropelvic obstruction and there is much diversity of opinion regarding the relative incidence or importance of each. Occasionally more than one cause of the ureteropelvic obstruction is discovered at operation and it is important that the secondary causes be recognized.

#### *Causes of Ureteropelvic Obstruction*

1. Aberrant or accessory renal vessels .....	27
At ureteropelvic junction .....	22
Proximal to ureteropelvic junction .....	4
Distal to ureteropelvic junction .....	1
2. Stricture at the ureteropelvic junction .....	3
3. Hypertrophy of the circular muscle layer of the ureter .....	1
4. Fibrous bands .....	4
5. High insertion of the ureter .....	10
Unassociated with other anomalies .....	0
Unassociated with other anomalies .....	0
Associated with "horseshoe" kidney .....	7
Associated with ectopic kidney .....	3
7. Combinations of above .....	6
	<hr/> 51

It will be noted from the table that the most frequent cause of obstruction is aberrant vessels. We realize that this is not a representative group since it is comprised of a younger age group than reported in other series.

### *1. Aberrant or accessory renal vessels—*

In the series of 51 cases treated in this army general hospital, this cause of obstruction has been by far the most prevalent. This has not been the experience of others but may be accounted for on the basis of the type of patient comprising this group. The accessory renal vessels usually supply a small area of kidney parenchyma on the lower pole and may either arise directly from the aorta or as a branch of the renal vessels. Two explanations are given for the mechanism of the obstruction. The pulsations of the vessel are thought to interfere with normal peristalsis of the ureter, thereby producing obstruction. It has been postulated that the obstruction is produced by ptosis of the kidney, kinking the ureter at the level of the vessel. The former explanation seems more plausible. The obstructing renal vessel may cross the renal pelvis, ureteropelvic junction, or ureter, depending upon its origin and upon what portion of the kidney it supplies. Accessory renal vessels are present in approximately 20 per cent of cases without hydronephrosis and care must be exercised in not overlooking the true cause of the obstruction when aberrant vessels are present in hydronephrosis.

### *2. Stricture at the ureteropelvic junction*

—This condition is perhaps the least understood of the causes of ureteropelvic obstruction and it is found frequently as the primary cause. The etiology is unknown and many explanations of its nature have been postulated. Most observers are of the opinion that it is of congenital origin, but others feel that chronic inflammation of the ureter and ureteropelvic junction may account for the stenosis. Some cases, however, are known to result from trauma to the ureteropelvic junction by external violence or by former operations on the renal pelvis.



**Figure 1**

The usual pyelogram of ureteropelvic obstruction revealing the symmetrical enlargement of the renal pelvis with a smooth inferior pelvic border. The ureter cannot be seen to enter the pelvis.



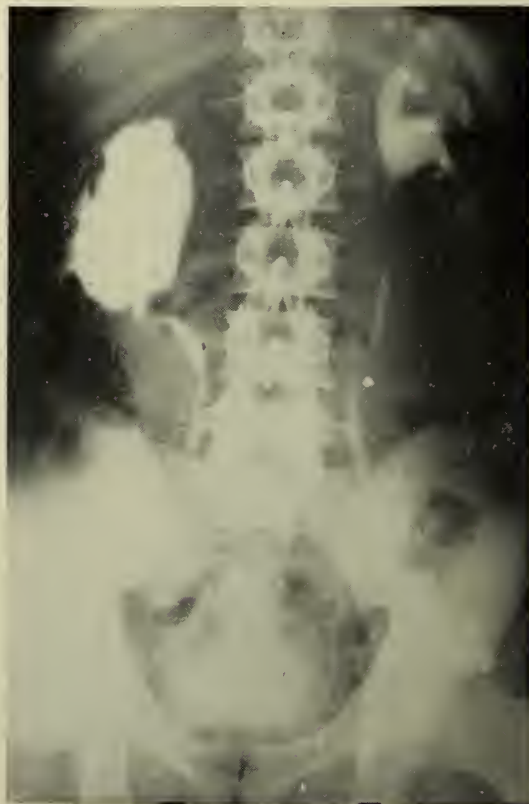
**Figure 2**

The typical crescent-shaped deformity of obstruction by an aberrant renal vessel crossing the renal pelvis proximal to the ureteropelvic junction.



**Figure 3**

Characteristic pyelogram of obstruction by an aberrant renal vessel crossing ureter distal to ureteropelvic junction. The dilated ureter above the vessel can be seen to enter the hydronephrotic sac.



**Figure 4**

Pyelogram of hydronephrosis caused by ureteropelvic stricture sequel to trauma to ureteropelvic junction. At operation ureteropelvic stenosis was discovered.



Figure 5

The typical pyelogram of ureteropelvic obstruction caused by hypertrophy of the middle circular muscle layer of ureter. Note that pelvis has not lost its funnel shape.



Figure 6

Hydronephrosis produced by fibrous bands. These adhesions were thought to have resulted from chronic inflammation. The constriction by the bands can be clearly seen.



Figure 7

The pyelogram of a "horseshoe" kidney with bilateral hydronephrosis. The ureters were found to have high insertion.



Figure 8

The filling defect at the ureteropelvic junction can be visualized, producing ureteropelvic obstruction.



3. *Hypertrophy of the circular muscle layer of the ureter*—This is not an infrequent cause of ureteropelvic obstruction and is produced by hypertrophy of the middle circular muscle layer of the ureter. This hypertrophy is of obscure etiology and occurs in an otherwise normal ureter at the ureteropelvic junction.

4. *Fibrous bands*—Fibrous bands occasionally produce ureteropelvic obstruction and are thought to be residual of perinephritic inflammation. These bands may be associated with other etiologic factors such as movable kidney and stricture at the ureteropelvic junction.

5. *High insertion of the ureter*—This condition is usually the result of hydronephrosis rather than the cause, although it may at times be the primary cause. The gradual enlargement of the renal pelvis from other causes in many instances displaces the ureter from its normal dependent position. In certain anomalies; namely, ectopy and "horseshoe" kidney, the ureter frequently has a high insertion thereby producing hydronephrosis.

6. *Non-calculus lesions of the renal pelvis*—Rarely one may find a pedunculated tumor of the renal pelvis, or a tumor near the ureteral orifice in the renal pelvis, as the cause of obstruction.

### *Symptoms*

Due to the insidious nature of this condition the symptoms develop over an extended period and are often misleading. Frequently the chief complaint of the patient would appear to be unrelated to the urinary tract. Pain in the loin, or upper quadrant, is usually the presenting symptom. The pain is dull, is not colicky in type and does not radiate. It is usually characterized by irregular periods of remission, and is almost never severe enough to require sedation. Occasionally the patient may complain of mild frequency of urination, dysuria, or cloudy urine. In most cases, symptoms directing the physician's attention to the urinary tract are lacking. Indigestion, accompanied by nausea, belching, constipation and vague abdominal pain represented the only complaint of 30 per cent of the cases reported herein. These gastro-intest-

inal complaints are usually present in a lesser degree when pain on the affected side is the chief complaint.

Physical examination is usually non-contributory in this condition and it is only rarely that the hydronephrotic sac is palpable as a mass in the flank.

Laboratory studies are of no help in suspecting the existence of ureteropelvic obstruction unless infection exists in the hydronephrotic sac and abnormal cellular elements are discovered in the urine. Voided renal function estimations are invariably within normal limits.

### *Diagnosis*

The diagnosis of hydronephrosis is based upon a careful urologic examination, including pyelography. Cystoscopy with retrograde pyelography is superior to excretory urography as a method of diagnosis since it offers an opportunity to measure the residual urine in the renal pelvis. It offers better visualization of the hydronephrotic sac, since the function of such a kidney is usually impaired.

At cystoscopy the ureteral catheter should be passed into the hydronephrotic sac, since failure to do so will result in an inability to obtain residual urine and poor visualization of the hydronephrosis when dye is injected. A ureterogram should likewise be made as this occasionally gives additional information when the obstruction occurs in the upper few centimeters of the ureter. Renal function estimations are of little value to the determination of kidney damage since there is, as a rule, good excretion of the dye following prolonged catheter drainage of the affected kidney.

The usual pyelographic picture of ureteropelvic obstruction is characteristic but the exact cause of obstruction is difficult, if not impossible, to determine. Indeed, at operation when more than one etiologic factor is involved, it is often a problem to determine the primary cause. There are, however, several characteristic findings in the pyelogram which suggest the cause of the obstruction. In the usual case the renal pelvis is seen to be uniformly and symmetrically enlarged with the inferior border of the hydronephrotic sac smooth and even. The ureter, as a rule, is not seen to

enter the dilated renal pelvis (Fig. 1). Figure 1 represents this type of pyelogram and it is seen with but slight variation in cases caused by aberrant vessels, fibrous bands, and by strictures. When the cause of the hydronephrosis is an aberrant vessel crossing the renal pelvis, a characteristic crescent-shaped deformity is produced by the presence of the dye in that portion of the renal pelvis distal to the obstructing vessel (Fig. 2). When the obstructing vessel crosses the ureter distal to the ureteropelvic junction, the dilated ureter can be observed above the obstruction (Fig. 3). In ureteropelvic obstruction produced by hypertrophy of the circular muscle layer of the ureter the pyelogram will as a rule reveal a dilated renal pelvis which has not lost its normal funnel shape (Fig. 5). In cases where the hydronephrosis is so large as to contain as much as 200 cc. of residual urine, this is not usually true. An abnormally high insertion of the ureter can be detected by pyelography (Fig. 7), but since it is usually only a secondary factor, except when associated with such other anomalies as "horseshoe" kidney and ectopic kidney, the detection of the abnormal insertion of the ureter is of little value. When lesions of the renal pelvis obstruct the ureteropelvic orifice a filling defect can usually be visualized in the renal pelvis (Fig. 8). Usually the determination of the direct cause or causes of obstruction is made at operation, and a diligent search should be made in every case to determine the presence of more than one factor. Before plastic surgery is performed, the caliber of the ureter should be determined by the passage of a probe or catheter through the ureteropelvic junction. By this method alone can a stricture at this site be discovered, since the external appearance is frequently normal.

### Summary

1. The causes of ureteropelvic obstruction have been enumerated and discussed.

2. Fifty-one cases of ureteropelvic obstruction have been reported and tabulated according to etiology.

3. Occasionally the cause of the ureteropelvic obstruction can be detected by pyelography and this is particularly true in obstruction by aberrant vessels proximal to

the ureteropelvic junction, hypertrophy of the middle circular muscle layer, abnormal insertion of the ureter, and non-calculus lesions of the renal pelvis.

4. The cause of ureteropelvic obstruction ordinarily must be determined by careful observation at operation.

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### JOURNAL DISCUSSES NICOTINE CONTENT OF CIGARS AND CIGARETS

"Thirty cigarettes, weighing about one gram apiece and containing about 2 per cent nicotine in the tobacco, might contain just about the same amount of nicotine as six cigars weighing about 5 grams apiece and with the same nicotine content," the March 23 issue of *The Journal of the American Medical Association* says in answer to an inquiry. Continuing *The Journal* says in part:

"About one fourth of the nicotine content of the tobacco may be expected to appear in the puffed smoke, though this figure may vary greatly, depending on the manner of smoking. Only about 12 per cent of the nicotine escapes with the exhaled smoke after inhalation, as compared with almost 33 per cent after simply puffing without inhalation, but in either case the bulk of the nicotine appears to be deposited in the mouth or air passages. Accordingly, it might be possible for the thirty cigarettes inhaled to yield about the same amount of nicotine absorption as the six cigars not inhaled.

"Since either cigarettes or cigars may vary greatly in their nicotine content, however, and the latter especially may vary greatly in size, and both may be smoked at widely different rates and with the discarding of greatly different amounts of tobacco and retained constituents of the smoke in the unburned stumps, this conclusion required much caution. Moreover, much nicotine may be absorbed from the unburned stump of a cigar by the user who chews or sucks as he smokes, while on the other hand the habitual spitter may rid himself by expectoration of some of the nicotine taken in.

"The nicotine discussed is the chief factor found in cigarette or cigar smoke which may be expected to affect the normal heart, with the production of changes in rate and rhythm and even in electrocardiographic patterns in some cases. Carbon monoxide in the smoke would be greater in the cigar smoke than in the cigarette smoke but rarely sufficient to produce symptoms. The same is generally true of the other constituents of tobacco smoke."

The Medical Association of Georgia will hold its next annual meeting at the City Auditorium, Macon, May 7-10, 1946.

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*



## THE BONE GRAFT IN ORTHOPEDIC SURGERY

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The bone graft as treatment came into general use about 1912 and most advances have therefore occurred in recent years, and tribute is paid to Albee, Hibbs, Campbell, Henderson, Orel, Boyd and others.

Albee popularized the inlay type of graft which is often and best suited to the tibia and bones of the forearm.

Campbell and Henderson advocated and popularized the massive onlay type of graft best suited for non-union of the humerus or femur. The term "massive" is employed to mean that the graft should be as large as possible.

Hibbs in his well known method, with many others, used the ever-becoming popular chip grafts which can vary from very small chips to the large sliver graft. Advantage in their use is abundance of supply and, more often, the lack of necessity for further incisions and opening the medullary canal, thus reducing shock and the possible occurrence of fat embolism.

The study of bone grafting teaches us that bone should be considered as a tissue, the survival of which is dependent upon good nutrition. Every effort should be made to favor the nutrition of the soft tissues about the fixed bone in the operative field. The periosteum should not be separated from the soft tissues about the surface of the fixed bone in the operative field. The best method of exposing the bone is to loosen the periosteum from it and not traumatize the tissues lying external to the periosteum. As in skin grafting, all infection must be controlled before proceeding in grafting, otherwise failure with necrosis and sequestration is inevitable.

Bone grafting is usually performed for non-union, whatever its cause, or to replace loss of substance, or to produce and hasten fusion. For years, six months has been accepted as a sufficiently long period to wait for union to occur. That non-union will occur can frequently be determined from the x-ray appearance of the bone ends, by

their separation or by the non-appearance of radiable callous. The type of injury, with the destruction of bone and soft parts and circulation, may have been the real cause of the non-union. Interposition of soft parts frequently interferes with bone healing. Repeated early manipulations, overpull or distraction, incomplete immobilization, infection or loss of substance may have played a part in its production. It is probably about 95 per cent preventable. In femoral fractures, if open reduction is necessary after eight weeks, some type of graft is recommended.

Regardless of the many theories advanced, the bone graft primarily acts as a means by which the blood circulation is re-established between the two ununited fragments, and when this happens union of the fracture occurs. In non-union, following compound fractures, grafting should not be attempted until six months after healing. In the past few years modern therapy has aided materially in shortening this period with safety. Then it is safe to proceed with scar excision and a pedunculated skin graft or dermatome split thickness grafts if the skin cannot be closed. After healing, radiant heat and massage are administered for two weeks and then, if latent infection is not lighted up, it is safe to proceed with the bone transplant. The earlier before puberty a graft is done, the larger the percentage of failures; so that statistics must be presented and weighed in age groups in children. Advanced age is no contraindication to bone surgery, but hemorrhage and shock are poorly stood. Therefore, operative procedures should be brief and well planned to overcome these obstacles. This is accomplished by the use of the preserved autogenous graft. The graft is taken often under local anesthesia, refrigerated at 37 to 40 degrees Fahrenheit, in citrated blood, and used when the next operative procedure is planned. I prefer and use this method in certain cases of spine fusion and femoral neck non-union and delayed union. Campbell preferred the graft alone, either tibia or fibula. I prefer and use the graft and nail combined, as it supplies osteosynthesis and maximum fixation with the elimination of plaster immobilization. I also prefer the



so-called modified method of spine fusion over the Albee or Hibbs methods, as there is less likelihood of fracture of grafts, and should infection occur the operation can be repeated. The graft can be cut so that it can be bent to conform to the spine.

Albee popularized the sliding inlay and inlay type of graft, especially useful for the tibia and certain cases in the bones of the forearm. These grafts must be cut very accurately to fit snugly in the trough, as they are self-retaining. Gill's massive sliding graft is also useful for bones of the forearm. There are many diverse patterns and bizarre shapes to make the inlay graft, but the straight inlay graft must be cut snugly to accomplish its purpose, and an error of the width of the saw will make for inaccuracy.

Campbell and Henderson were the first exponents of the massive onlay graft most useful for the humerus and femur. The medullary canal is re-established, the bone ends freshened and throughout this area is placed endosteal and cancellous bone. In preparing the graft bed, scar tissue is removed, the cortical bone is flattened with a sharp osteotome, the outer one-third of the cortex being removed so that the blood supply will come from the medullary circulation. As proven by Johnson's work, the periosteal blood supply nourishes the outer one-third of the cortex and is not sufficient to effect healing in a fracture. Non-union occurs when the nutrient artery and the metaphyseal vessels anastomosing with it are blocked. With the use of this type of graft, the percentage of failures was reduced. Henderson reported about 13 per cent failures over a period of about twenty years at the Mayo Clinic. Autogenous and beef bone screws were first employed as a means of graft fixation, but at present fixation with vitallium screws is much simpler and more secure. Absolute fixation of the graft in its bed is necessary, otherwise death of the graft will occur. Also secure plaster immobilization is essential, to be continued until x-ray examination shows the graft to be an integral part of the bone. Firmer fixation can be obtained by plate fixation with a graft and with screw fixation to the opposite cortex.

The peg type of intramedullary graft is mentioned only for condemnation, as it has no place in the treatment of non-union or as a means of fixation except at the metaphyses of long bones, the neck of the femur, the olecranon, and the metacarpals.

Chip grafts have a wide field of usefulness where immediate fixation is not needed. Surgical shock has been a too frequent cause of death in operative spine fusion and is practically eliminated by the multiple chip graft method, and inasmuch as the medullary cavity is not opened this procedure also reduces the risk of fat embolism. These grafts should be small—less than the size of the fingernail—and with their use massive fusion can be produced for compression fractures, spinal tuberculosis, lumbar-sacral fusion, in scoliosis, and in spondylolisthesis where the fused area will be ultimately subjected to considerable strain. Other uses are to augment any arthrodesis—in corrective osteotomy—to gain length and hasten union in the surgical treatment of certain bone tumors; namely, localized osteitis fibrosa cystica and benign types of chondrosarcoma as aids in filling defects and stimulating the formation of bone after the tumor cavity has been thoroughly cleaned out. They are easily obtained in large quantities from the tibia and ileum and operative area.

Curettage and packing with bone chips is now recognized as the best method of treating localized fibrocystic cavities and giant cell tumors. Recurrence is common and the operation oftentimes has to be repeated. The process of repair is not understood as it is a complicated one involving many chemical and pathological changes. It is an interesting moment in practice to examine the radiogram of a patient seen for a fracture or suspected tumor and find a cavity in the shaft or near the end of one of the bones.

Hallock reports several cases of congenital pseudoarthrosis with union after his method of troughing and filling with multiple chip grafts from the tibia or ileum.

In fusion of the thoracic spine, one of the best methods is to use the transverse

processes taken subperiosteally and used as chip grafts with also the dorsal spinous processes. This reduces shock and loss of blood, removes the necessity of multiple scars, increases strength of fusion, and gives a wider and deeper fusion area. About 50 per cent of spine fusions are of the dorsal spine.

We are indebted to Boyd for the development of the dual bone graft which is best suited for difficult and unusual non-unions, non-union near the joints and for bridging bone defects including gunshot wounds and compound fractures. These are difficult surgical problems due to osteoporosis of the short fragment, its thin cortex and the soft cancellous bone present, making it hard to hold the single graft. The dual graft gives a forceps-like action of the grafts and better mechanical fixation. It can also be used in non-union of one of the bones of the forearm instead of shortening the other bone and without the likelihood of the hour-glass contraction at graft level of the defect. This type of graft was first employed in the most difficult of all non-unions to treat; namely, congenital pseudoarthrosis of the tibia with a much greater percentage of cures. Grafts from the mother or father are used with vitallium screw fixation. The pseudoarthrosis and scar tissue are excised. Care must be taken not to place screws too close to the fracture site, and endosteal and cancellous bone are used as with the massive onlay technic. In this type of non-union, the fragment ends are eburnated and avascular and are excised down to normal bone. The length of the grafts depends on the amount of lost substance or poor bone to be bridged. The graft should be long enough so that it has twice as much length contact with normal bone on each fragment as the lost substance or poor bone to be bridged.

There are a few other types of graft that I would like to mention. Orell of Sweden, whose work before World War II was a fascinating masterpiece, employed os porum or os novum and boiled bone instead of the commonly used fresh autogenous graft. Os porum is chemically treated bone freed of fat, protein and connective tissues, which has certain advantages as a fixation material. Os novum is prepared by subperiosteal

implantation of os porum and is much softer, as it is immature bone with great proliferative powers and is used as a method of osteosynthesis where extraskkeletal connective tissue separates two bones to be joined by transplantation, as in osteosynthesis of the spinous processes in tuberculous pseudoarthrosis where the transformation of new bone formed after the implantation of os novum proceeds more uniformly than is the case after the transplantation of fresh mature bone, probably because calcium containing necrotic bone prevents the formation of new bone. The newly-formed splint is firm throughout and weak areas or defects do not appear as readily as after transplantation of mature fresh bone, and consequently fractures do not occur. He has observed no cases of fracture after the use of os novum and reports good results in cases of pseudoarthrosis without the excision of the soft tissue of the pseudoarthrosis. Much further experimental work to evaluate these materials is to be done and research along this line will provide us with increasing knowledge of the nature of bone formation with advancement of bone graft surgery. It is to be hoped that we will receive a continuation of this work following this war.

The osteoperiosteal graft under plate fixation as advocated by McBride is a valuable early procedure to stimulate and insure union, sometimes in the face of existing infection. This can be carried out opposite the area of infection in many cases of compound fracture.

Mention should be made of the centrally placed bone graft in joint arthrodesis, especially applicable to the knee and ankle. It affords immediate and positive fixation in the position of election, expedites fusion and hastens osteosynthesis. It also does not disturb the growth process when used in children, if care is taken to place it centrally. Osteosynthesis is also a valuable procedure preceding extensive bone grafting as in extensive loss of bone from trauma, tumors, or infection, as of the fibula to the tibia followed by graft.

There are many methods of arthrodesis of the wrist, but I prefer the use of cancellous grafts from the ileum. This is a very good procedure with many uses in paraly-



sis of the upper extremity and infectious and traumatic arthritis, and its field of usefulness may be compared to that of arthrodesis of the foot. This type of graft secures rapid and certain fusion.

Non-union of ribs, although rare, sometimes occurs in one or more ribs. Here the tibial cortical graft in the shape of a shuttle is a useful method.

Fusion of the metacarpals of the thumb and index finger by a keystone-shaped graft is a useful method to restore and maintain functional position in opposition to the thumb. A simpler subastragular arthrodesis in old fractures of the os calices, using the posterior approach and tibial graft, is advocated by Galles, and the fibula is used to bridge longer defects in the forearm bones.

I have attempted to present some of the principles and methods of bone grafting with mention of a few of their applications. We may expect some further advances out of and after the present world conflict, probably from Kofmann of O'Dessa, USSR; Orell of Sweden, and others. In closing we may say that our present principles and methods of bone grafting seem well perfected, but we should keep an ever open mind to newer concepts and methods in order to better serve humanity, in this age of ever-increasing speed and mechanizations.

#### A DAY FOR HONORING DOCTORS

Today is Doctors' Day in Georgia. There will be just as many sudden fevers, as many croupy babies, as many desperate diseases, real or unreal. There will be that same old circle of uneasy men and women slumping in those weight-worn chairs in doctors' offices, thumbing old copies of fishing magazines as they wait their turn to hand their mysterious burdens to a mortal man.

Nevertheless, it will be Doctors' Day. The doctors won't do any self-appraisal. That takes time. But there are those who will remember it is the anniversary of Dr. Crawford W. Long's discovery of anesthesia, and in his memory, they will honor all men and women physicians and surgeons whose profession is selfless service at the moment of greatest need.

This is a chance, too, to bow to the tired men who are laying down their stethoscopes and scalpels after long careers in medicine. In Atlanta alone, more than 200 medical men have come back from the war, to take up their practices where they left off. Many of their elders are closing up shop, taking a holiday after their long emergency.

We honor Georgia's doctors on their day.—*The Atlanta Constitution*, editorial page, March 30, 1946.

## SARCOIDOSIS

### Report of Case

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Sarcoidosis is defined as a chronic, indolent and benign infectious disease of unknown cause involving the skin, lymph nodes, eyes, salivary glands, lungs, and bones of the hands and feet especially. In addition to these conspicuous lesions, disseminated systematic manifestations bespeak widespread pathologic changes.

Most cases show a clinical picture of a generalized process but some show only changes limited to some localized organ or organs with more or less extensive involvement of the lymph nodes. The most common cases are apparently those with pulmonary involvement in combination with systematic lymphadenopathy. Some show only uveoparotitis or Mikulicz's syndrome; others show splenic enlargement, bone involvement, skin involvement, etc. There may be only one manifestation of the disease or there may be any combination.

Thirty-five cases reported by David Reiser (April-May 1944 *American Review of Tuberculosis*) showed the following organ distribution:

Lymph Nodes, puerperal .....	35
Lymph Nodes, intrathoracic .....	30
Lungs .....	33
Skin .....	14
Bones .....	9
Spleen .....	8
Liver .....	6
Eyes .....	7
Mucous membrane .....	4
Parotid gland .....	2
Lacrimal gland .....	2
Heart .....	2
Nervous system .....	2
Serous membrane .....	2
Breast .....	2

**Etiology.** As stated previously the cause is not definitely known. Tuberculosis has been cited as the underlying cause by most observers, but Koch's postulates have not been fulfilled. The bacillus of leprosy has received some attention in this connection. A filterable virus has been incriminated but has not been proven guilty. This disease process may occur at any period of life. Drs. H. C. Sauls and Carter Smith, of Atlanta, recently reported a case in a 80 plus



year old white woman. There is apparently some predilection for the Negro in this country. I recently saw two cases in Negroes at Charity Hospital in New Orleans. Of Reisner's 35 cases there were 30 negroes and 5 whites, of whom 11 were males and 24 were females. Both cases in New Orleans were males. Although these cases frequently have syphilis, it has been definitely proven not to be the cause.

*Pathology.* The fundamental lesion is granulomatosis. Large pale epithelial cells are collected in isolated nests or well-defined nodules. As a rule, these areas are not sharply demarcated from the normal tissue. An occasional pale multinucleated giant cell completes the picture. Neither necrosis nor caseation is observed. In its natural evolution fibrosis may be anticipated. It seems that the disease may involve almost any part of the body.

*Symptoms and Physical Findings.* General symptoms are surprisingly few. Onset is insidious and progress is slow.

1. Skin lesions may predominate the picture with diffuse or nodular involvement lasting for months, and then heal. They are painless and do not itch. Secondary infections may occur and ulceration results. Skin lesions are not an essential part of the disease.

2. Swelling of lymph nodes is perhaps the most frequent manifestation. The nodes feel rubbery and are easily movable and not tender. Any of the nodes in the body may be involved, including mediastinal and peribronchial nodes that may extend into the lungs.

3. Lungs: Pulmonary involvement may be due to extension from the peribronchial nodes into the lung parenchyma and thereby give a very characteristic x-ray appearance. Many cases, however, with extensive x-ray findings have very little subjective pulmonary symptoms. They are frequently found on routine x-ray examination of the chest.

4. Bone changes: When present these changes are practically pathognomonic of sarcoidosis and have a very striking appearance in the x-ray film. The appearance is

cyst-like changes in the phalanges of the fingers and toes but may involve other bones of the body. Only about one-fourth of these cases show these bony changes.

5. Splenic and liver enlargement occurs rather frequently in sarcoidosis. In Reisner's 35 cases there were eight cases of splenic enlargement or involvement.

6. Heart: The heart muscle may become involved with the sarcoid process or the heart may be affected indirectly by involvement of the lungs.

7. Eyes: Every part of the eye may become involved in the process, most frequently in the lacrimal glands in association with the parotid gland involvement or Mikulicz's syndrome.

8. Mucous membrane of the respiratory passages may be involved with the sarcoid process and give rise to lesions in the nose, throat, etc.

9. Lesions may occur in almost any part of the body, as the thyroid, pancreas, kidney, adrenals, epididymis, testes, peripheral muscle, etc. It has been suggested that this may be the process described under cicatrizing enterocolitis or regional ileitis. There may be an eosinophilia of 6 to 35 per cent. Increased plasma protein in the blood has been reported. The blood calcium frequently is increased.

*Diagnosis.* Sarcoidosis is most frequently confused with Hodgkin's disease, tuberculosis, and syphilis. The x-ray is useful in the diagnosis of the lung, bone, and intestinal forms. The positive diagnosis is made only by microscopic examination of excised lesions or nodes.

*Treatment.* There is no specific treatment known at the present time. Various drugs and types of therapy have been used with practically no effect. General hygienic measures and palliative treatment is the only course at present. Arsenic, x-ray, radium, gold, etc., have been tried.

*Prognosis.* Spontaneous recovery may be anticipated in a majority of the cases. Approximately 10 per cent of the reported cases have developed clinical tuberculosis. A 5 per cent mortality rate is reported.



Figure 1  
Sarcoidosis of the lungs.

#### REPORT OF CASE

W. C., a colored man aged 26, came to me Aug. 7, 1944, complaining of weakness, loss of weight, shortness of breath, and a generally run-down condition. He gave a history of having been somewhat weak and run-down for several months but had gotten worse during the past week or ten days. There is no definite history of any acute onset. He was born and has lived most of his life in Calhoun County, Georgia, just below Carnegie, but has spent some time in Florida during the past few years. He has been back home about six months.

**Past History:** Has never had any severe illness but has had bronchial asthma since childhood. Since he has been sick, cough and asthma have seemed worse. He gives a history of having taken about 60 injections for his blood, but denies having a penile sore. Has had Neisserian infection.

**Family History:** One brother dead, cause not known; 2 brothers living and well, mother and father living and well.

**Examination:** Negro male about 26 years old showing evidence of emaciation.

**Head:** No exostoses or particular irregularities.

**Eyes:** Negative; mouth, fair condition; throat, tonsils moderate size but not especially inflamed.

**Neck:** Cervical lymph nodes enlarged, movable and not tender. No thyroid enlargement.

**Chest:** Patient is dyspneic of the asthmatic type. Rales (musical in type) heard all over chest. Unable to determine anything further from chest examination (physical).

**Heart:** Rate regular but rather rapid.

**Abdomen:** Flat. No tenderness, no masses. Liver and spleen not palpable.

**Genitalia:** Negative.

**Extremities:** No edema or paralysis; no deformities. Reflexes: Physiologic.

**Lymphatics:** Generalized lymphadenopathy. Nodes have firm rubbery feel and are freely movable and not tender.

**Laboratory:** Urine normal; Kahn test positive; sputum, negative; R. B. C., 5,500,000; W.B. C. 7,600;

Hemoglobin estimate 100 per cent; Differential-lymphocytes 35 per cent, neutrophils 60 per cent, eosinophils 5 per cent.

X-Ray of chest showed a characteristic appearance that I think illustrates a case of sarcoidosis involving the lungs (Figure 1).

Biopsy of inguinal lymph node was done. Pathologic report from Dr. Warren B. Matthews, of Atlanta, was sarcoid of lymph glands.

#### Summary

1. Report of a case of sarcoidosis has been given.

2. This disease is probably more frequent than we realize and should be thought of and looked for more often.

3. It is more frequent in the Negro race in this country.

4. It is a more or less self-limited disease, but may be prolonged for years.

5. No specific treatment for sarcoidosis is known.

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Read before the Randolph-Terrell Medical Society Sept. 1, 1944.

#### A HODGE-PODGE OF PAST EXPERIENCES

C. K. SHARP, M. D.  
*Arlington*

Back in the days of the gay nineties I was seized with the desire to practice the noble art of administering to and, possibly, healing the sick. In October 1895, 50 years ago, I entered upon a three-year course of lectures—mostly didactic—in an accepted regular medical college. My class was the last to finish in three years. A few years prior to this, only two years were required.

The credentials required for entrance was a first grade teacher's license and a good moral character. The first I procured from my county school commissioner on my first vacation, as I was told that it would have to be forthcoming before I could enter my second course. This assured my continuance in college. My good moral character was probably taken for granted as I never heard of it being investigated.

What a contrast to the requirements of today: a requisite number of literary col-



lege years, plus a premedical course of a prescribed number of years, with possibly an internship. Internships were hard to procure and then only to top-ranking students, due to the dearth of hospitals throughout the country. After all, all the then known facts in medicine could be covered in two or three years. The laboratories were very elementary; blood chemistry was in its infancy or almost non-existent. The chemistry of digestion and assimilation likewise. The function of the ductless glands, furnishing what is now known as endocrines which harmoniously control the various metabolic processes was practically, with few exceptions, unknown.

Nothing was said of vitamins, the nutritive elements in foods, which of late have been overemphasized and disgustingly commercialized through the radio and lay press. We know a well-balanced ration of food of proper quality and properly prepared contains all the necessary elements to sustain a healthy body, which has always been the case in the past. We have simply found out what these elements are, have named them vitamins and have given them alphabetical designations, and have used them as accessories in nutrition.

Much of the medicine taught us in the past had to be unlearned and the scientifically correct methods learned as best we could.

Many of we old fellows can remember with almost tears in our eyes the many little short graves we have been responsible for through our ignorance of the common-sense laws of nutrition in infantile intestinal disorders. These little patients would dwindle away and die, not of the disease but of dehydration and starvation. I have had old grandmothers inform me that "Doctor you are starving that child to death"—which then was resented but now we know they spoke the blessed truth. In this enlightened period, this prolonged wasting away in early life is prevented and but a few days are required to have them normal healthy babies.

The mortality in typhoid fever was unnecessarily high due to inadequate feeding. They too starved to death. Since typhoid immunization was introduced this scourge

has been practically eliminated. It is said that typhoid killed more American soldiers in the Spanish-American War than Spanish bullets. In the last two world wars, typhoid is not a serious problem.

I dare say that pneumonia with its multiplicity of types as now known was never cured—with the term cure properly employed—by any means used in the past. Treatment, all the way from blisters to veratrum, closed rooms devoid of atmospheric air, and the use of nearly every drug in the pharmacopeia with no curative effect. We knew two main types, lobar or croupous, and lobular or bronchopneumonia. We do not hear of these forms nowadays, but as types 1 to 30 odd. As to modern treatment, the sulfonamides, penicillin, specific type serums, plus oxygen, have wrought miracles, and by these or a combination of them we can confidently expect a cure and thereby lessen the chances of empyema. The same can be said of diphtheria, the former slayer of children, through prompt and adequate serum therapy. Diphtheria will be an unseen disease in the near future through universal immunizations.

Whooping cough has been cured, definitely modified or prevented by specific vaccines and ere long complete immunity will be lastingly conferred. The same may be said of measles, scarlatina and other childhood diseases. Many diseases now considered incurable will be conquered as a result of the work of our patient men of research in cooperation with our learned clinicians.

It is most probable that syphilis was never cured by the old methods of treatment.

Our county health units have transformed these once unhealthy sections into areas fit to live in and where industries are willing to establish their enterprises and in course of time will move in and flourish. Our school system in its evolution from the "little red school house" to district and county-wide schools has played a big part in rendering students health conscious.

And now, you might be interested in some experiences of a personal nature. My first year in practice was spent in a small



farming community where I was asked by the incumbent to relieve him of his practice for awhile before I located. To this I consented as I wished to break the ice somewhere. I held on a year, for he never came back but left me "with the bag to hold," as in a snipe hunt. There was a limited amount of work to do and time hung heavily on my hands, but I did garner enough funds for a meager living. Furthermore, there was a constant yearning for amusement which was nonexistent except through my own devices, so to playing pranks I naturally drifted aided by a young man my age and a congenial spirit. One of my prank victims was my old housekeeper and washerwoman. I slept in the rear room of my office in a folding bed. I had been up all night on a maternity case and reached my office about the time I usually arose. It occurred to me to scare old Harriett. I placed my skeleton in the bed and spread a sheet over it. When she came in to arouse me as was her custom, and hearing no response to rap and call, she folded back the sheet and saw the grinning skull. From my concealed position in an improvised closet I witnessed an expression of horror I had never seen before; she left the house post haste, exclaiming as she ran "The doctor is dead and dried up." After she left I quickly removed the skeleton to its hiding place, then got in bed myself. When the crowd of acquaintances came to investigate, with old Harriett bringing up the rear wild eyed and in a state of hysterics and finding me in life, they began to question her sanity which she protested vehemently. Now, the outcome of this prank cost me a perfectly good and faithful servant, for she never came back and would never pass near "that haunted house."

My office was in a two-story frame building, the upper floor of which was used by a merchant to store his funeral supplies. A very suggestive location for a doctor's office.

Another prank was perpetrated on an old Negro blacksmith whose shop was a short distance from my office. He was knock-kneed to the Nth degree and used a short cane to help him along. My co-partner, in what should have been called crimes, was

present when a man in a wagon came for a coffin. When asked who was dead he replied that no one was dead but as the man was so near dead they decided they would get the coffin and have it ready. The coffin was placed in the wagon and hauled away, but before he reached his destination he was met in the road and told to carry the coffin back as the man had revived and gotten better. This was done and the coffin returned from whence it came. Now, old Bill the blacksmith saw all this, as he never missed anything that went on in the settlement. My friend and I contrived to scare Old Bill. I got in the coffin which was too short, but by drawing up my knees with my forehead resting against the lid which rested on the end of the screws, I managed to crowd in. Frank called Old Bill to help him move the "corpse". He taking the narrow end while Old Bill took the wide end. When they raised me up I saw his arm across the space between the lid and coffin, and with two fingers pinched him on the arm. This caused him to drop his end while Frank held his end. The sudden impact of my head against the end of the coffin caused quite a bump on my head and the sight of many stars. Old Bill hustled away not taking time to get his cane, and by the time I was disincorffined he was up the street fifty yards, a foot taller and legs as straight as mine. As a result of these pranks, it became rumored among the Senegambians that I was a haunt and that the house was haunted. So I just *had* to move.

In the following fall I hooked up Old Dobbins and drove to the reported "sickliest town in Georgia"—Arlington. At that time it well deserved its reputation for I soon found almost house-to-house cases of malaria in all its forms; simple tertian, algid or congestive chills, estivoautumnal and that much-dreaded form commonly known as "hemorrhagic fever," the latter caused by the breaking down of red cells due to uninterrupted malaria. Without any known prophylactic other than quinine, malaria was taking a heavy toll of the people. About this time the anopheles mosquitoes were proven to be the carriers of malarial parasites and not airborne or miasmatic as former-

ly taught. After this most valuable discovery preventative measures were practiced and today malaria is a comparatively rare disease in this formerly worst infected section of Georgia.

I was confronted with a somewhat amusing case of malaria in 1900. A man aged 40 but who looked 70, rode up in front of my office, bareback, on a Texas pony. With eyes sunken, cachectic, hollow-cheeked, with a few gourd-seed teeth that did not hit, he sauntered into my office saying: "Hie Doc, I hear you can cure the chills and fever." I replied that I made a pass at 'em, how long have you had 'em? "All my life" he replied; "they say I had em as soon's I struck air and to my certain knowledge I've been having 'em ever since I can remember." After giving him a once over and particularly observing an enormous spleen, I decided to make an effort to straighten him up. I filled a jug with a concoction containing ample quinine, with some iron and a laxative made into a solution with sulfuric acid, and directed that he take a tablespoonful three times a day as long as he lived. After a month or so he returned the jug to be refilled. The following late fall he came in on the same pony, much more of a burden for his steed, and asked for his bill, which had never been charged as I considered him a worthy charity case. He reached down into a pocket that extended almost to his knee in his homemade jeans pants and withdrew an enormous roll of greenbacks and gold certificates and after a search found a \$5.00 bill—my fee. He informed me that he had sold his farm and was on his way to Texas. I wished then and there for a kicking machine for my own personal use. One cannot tell by appearances what an individual is able to pay, which reminds me of one of Robert Burns' imperishable poems:

What though on homely fare we dine,  
Wear Hoddin grey and a' that  
Give fools their silks and knaves their wine  
A man's a man for a' that.  
For a', that and a' that  
An honest man tho' ere sae poor  
Is king of men, for a' that.

I could relate many amusing incidents which have occurred during my 47 years of practice, but I feel sure your patience is already taxed. But I want to say that I

have derived much fun in the practice of medicine and would admonish young doctors starting out not to take their profession too seriously. Mix a little amusement along with it. Takes the mental fag out of your life. Work up your cases as best you can and provide for them as reason dictates, then go home and throw them off your mind, sleep the night through and awake the next morning refreshed, with clear mind, ready for new patients.

In conclusion, I want to say that I was born 50 years too soon, and have often wished for today's opportunities in schools of medicine, but we old fellows have doubtless done a little good along the way, even though our diagnoses have been largely guesswork, without the immediate aid of laboratories and instruments of precision, and a clientele unable to pay for these refinements.

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#### MALIGNANT LYMPHOMA

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JOHN FUNKE, M. D.

*Atlanta*

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This is not written with the view of settling the question as to how diseases of the lymph nodes should be classified. This question will continue to be debated until some etiologic factor is discovered, but the classification as stated by Gall and Mallory, to my way of thinking, is the most workable yet announced.

The term malignant lymphoma has been applied to enlargements of the lymph nodes for years.

The first problem presented to the clinician is whether he is dealing with an enlargement which is due to some inflammatory or benign condition, or whether he is dealing with something more serious, as a malignant or life endangering lesion. The life endangering lesions are malignant lymphomas.

Of the malignant lymphomas one must determine whether he is dealing with a condition which is somewhat rapid in its course, as an acute process, or is more or less drawn out. Of the former the treatment is of an



appeasement type, while of the latter the terminal event may be delayed for a period of years and even an apparent cure in some very few cases.

If we study the minute histology and the development of the elements comprising these organs, the classification of Gall and Mallory is pure logic.

Their classification based upon the histology is as follows:

Stem cell .....	malignant lymphoma;
Clasmatoeytic .....	malignant lymphoma;
Lymphoblastic .....	malignant lymphoma;
Lymphocytic .....	malignant lymphoma;
Hodgkin's sarcoma .....	malignant lymphoma;
Giant follicular .....	malignant lymphoma.

In any classification there is practically always merely a fairly working sketch which will not cover completely, nor entirely satisfactorily, all malignant conditions of the lymph nodes.

I have in mind a lesion found in the lymph nodes of individuals of almost any age, which is definitely malignant and which one cannot clinically differentiate from enlarged lymph nodes of the aleukemic states, nor with definiteness from ordinary Hodgkin's nor from the growths which Ewing classifies as malignant lymphocytoma or lymphadenoma. The adenoma is not clear to me. I don't see any relation or connection.

The nodes of the lesion I have in mind and to which I refer as malignant lymphoma of the lymphocytic type are discrete, movable, rather firm and of rather slow growth, although now and then rather rapid in growth. The patient sooner or later will show evidence of disease, will lose weight, will become fatigued easily. Sometimes, like in other forms of lesions of the lymph nodes, the enlargement becomes noticeable after some acute disturbance of infection, consequently the clinician has in mind some simple enlargement of the lymph node, really a hyperplasia.

There is no one manifestation which will aid one in making a definite clinical diagnosis, and even after the growth is removed it is impossible to make the diagnosis from the gross appearance.

Microscopically the normal architecture of the lymph node is not entirely obliterated, such as we see in most of the other malignant lymphomas. The follicles are fair-

ly prominent and are largely made up of small cells with a scanty feebly basophilic cytoplasm and a comparatively large pachychromatic nucleus, although in the center of the follicles there are present larger cells. In the areas between the follicles the cells are of the lymphocytic type but are not coherent and the intercellular spaces are wide, although there is not much increase in the reticulum.

Whether the lymph nodes in the mediastinum, in the abdomen, or in the retroperitoneal area are ever involved, I am unable to determine, since I have never had occasion to do an autopsy on an individual suffering with this type of malignant lymphoma. Neither do I know whether there is ever bone involvement such as is seen in Hodgkin's disease now and then. Even in lymphatic leukemia the marrow is often involved. The bone lesions in Hodgkin's was not described until 1904, which was many years after the disease was first described.

#### THE ARMY MEDICAL LIBRARY

The Army Medical Library had its beginning in 1836 while Joseph Lovell was The Surgeon General. It remained a small collection of medical books and pamphlets in the Office of The Surgeon General for some thirty years. In 1865, Dr. John Shaw Billings who had been an Army Surgeon in the Civil War, became an assistant to Surgeon General Joseph K. Barnes. Under Billings' guidance, the Library as a great research institution got its start.

From 1865 to 1887, the Library was housed as a part of the Army Medical Museum in the old Ford's Theatre on Tenth Street in which President Lincoln had been assassinated. In 1868, it boasted five thousand volumes.

The Surgeon General reported in 1879 that there were fifty thousand books on the shelves, and the following year recommended that a building be constructed to house the Library's expanding collection, to cost \$250,000.00. This building, located at 7th and "B" Streets (now Independence Avenue) S. W. and still occupied by the Library, was completed in 1887.

Under the direction of The Surgeon General, Dr. Billings published in 1876 a *Specimen Fasciculus* showing the style and arrangement planned for the *Index-Catalogue*. In the next four years, with the assistance of Dr. Fletcher, he worked at preparing the copy of the first *Index-Catalogue*, the greatest medical bibliography which began to appear in 1880.

One year before the publication of the *Index-Catalogue*, Dr. Billings and Dr. Fletcher hit upon



another bibliographical expedient intended to give physicians a classified record of the current medical literature of the world, month by month. This was the *Index Medicus*, the editorial management of which was principally in the hands of Dr. Fletcher. The first monthly number of this publication was issued on January 31, 1879. Except for a brief interval, it was carried on until 1927 when it was taken over by the American Medical Association.

Through his untiring efforts, Dr. Billings accumulated a store of medical literary treasures of the 15th, 16th, 17th, and 18th centuries, unobtainable today. His output of 171 medical publications in the course of half a century bear witness to his great energy. Extremely versatile, he was considered a good judge of men, having selected Fletcher and Garrison for the Army Medical Library, and Welch, Osler, and Halsted for the Johns Hopkins.

After thirty years of service to the Library, Colonel Billings departed with his laurels to take his new position as the first Director of the New York Public Library.

From the inception of the Library to the present time, sixteen librarians and two Directors have held office as follows:

#### LIBRARIANS

Colonel J. S. Billings (1868-1895)  
 Colonel D. L. Huntington (1896-7)  
 Surgeon J. C. Merrill (1898-1902)  
 Major Walter Reed (1902-died in office)  
 Brigadier General Calvin DeWitt (1903)  
 Brigadier General W. D. McCaw (1903-13)  
 Colonel C. C. McCulloch, Jr. (1913-18)  
 Brigadier General F. A. Winter (1918-19)  
 Colonel P. E. Straub (1919)  
 Major General R. E. Noble (1919-24)  
 Colonel J. M. Phalen (1924-27)  
 Colonel P. M. Ashburn (1927-32)  
 Major Edgar Erskine Hume (1932-6)  
 Colonel Harold W. Jones (1936-July 1944)

In July 1944, the offices of The Director and The Librarian were created, to be occupied by an Army Medical Officer and a career librarian, respectively. The following is a list of The Directors and The Librarians:

Colonel Harold W. Jones, The Director  
 (July 1944-Aug. 1945)  
 Colonel Leon L. Gardner, The Director  
 (Sept. 1945- )  
 Captain Francis R. St. John, Acting The  
 Librarian (July 1944-June 1945)  
 Mr. Wyllis E. Wright, The Librarian  
 (July 1945- )

After Billings' departure, we find that in a period of eight years there were five Librarians, one serving for four years and the others averaging about a year. Fortunately, Dr. Robert Fletcher remained until his death in 1912, assisting in the work of the *Index-Catalogue* and as editor of the *Index Medicus*. Subsequently, Dr

Fielding Garrison took over the work of the *Index-Catalogue* and later became editor of the *Index Medicus* (1912-27).

Since Billings' time, the *Index-Catalogue* has had only four editors—Fletcher, Garrison, Alleman, and Mayer.

In 1919, the Librarians had been limited to a four-year tour or occasionally a little more, which applied to General Noble, Colonel Phalen, Colonel Ashburn, and Major Hume.

In 1933, a proposal was laid before the President by petition of certain members of Congress to transfer the Army Medical Library to the Library of Congress. Through the opposition of the Librarian of Congress, the Surgeon General and the medical profession, this was prevented. During the depression years, Congress in great measure withdrew its support from the Library. The *Index-Catalogue* had to be suspended for three years.

In 1936, Colonel Harold W. Jones took office, serving for a period of slightly less than ten years. In 1938, after many hearings, a bill was introduced to provide a new Library and Museum Building. After lively agitation and much favorable testimony, the bill finally failed in the last days of the 75th Congress. Some time previously, the possibility of locating the Army Medical Library and Museum at the Army Medical Center was considered. This plan received considerable opposition from the medical profession in view of the inaccessibility of this location. The permanent location of the Library on Capitol Hill was favored by Surgeons General Reynolds and Magee.

The location was definitely settled when in 1941 Congress passed a bill authorizing a new Library and Museum to be located on Capitol Hill. It had appropriated a year before, the sum of \$130,000.00 for plans to be drawn. After extensive consultations with the Librarian and an advisory board of medical officers, blueprints and artists' drawings were made by the architects, Eggers and Higgins of New York, who spent approximately a year in developing the general plans.

On December 7, 1941 came the war with Japan, and with it were dashed all hopes of the immediate erection of the new building which was so badly needed. But the demands of war made it essential that the Library's services, in spite of inadequate space and inadequate personnel, be greatly expanded.

These demands were met through a reorganization of the staff and by moving a part of the Library to another city, not only for safety but for the ultimate preservation of the books which had suffered severely by lack of proper housing.

The Cleveland Branch of the Army Medical Library was established in July 1942, in the Allen Memorial Medical Library where space was provided to house 90,000 volumes. A Cleveland bookbinding firm was engaged to start the great work of repairs and rehabilitation.

In 1945, the Library took over as an official publication the *Current List of Medical Literature*, previously issued as a private publication, although drawing its materials from entries prepared for the *Index-Catalogue*. The *Current List* presents each week a general view of the contents of the periodicals received in the Library.

During wartime, the Library has provided a service beyond that which could be expected with the limitations imposed upon it. Through the years, its collections have grown to the point where over a million items, of which over five hundred thousand are bound volumes on every phase of medicine, are available to support medical research. The Library now has 513 of the known medical incunabula. Its personnel has increased within a few years from a mere 30 to 150, of whom a large percentage are professional.

During wartime, there was greatly increased reference work for military and naval hospitals. There were many more requests for bibliographical assistance. There was a great increase in photoduplication and the distribution of microfilm to overseas units, for Free China, and for the United Nations. This latter service was started in 1939.

The Library has not limited its services solely to the military doctor, but serves the public in every way possible. Its loans go to every state in the Union, and its photoduplication service sends microfilm copies of medical literature to every corner of the globe. The *Index-Catalogue* and the *Current List of Medical Literature* continue to be published regularly.

A new Army Medical Library building on Capitol Hill adjoining the Library of Congress occupies a definite place among the projects outlined by the Fine Arts Commission of the District of Columbia as a part of its \$400,000,000 postwar program.

Plans for this new Library building have been revised by the present Director, Colonel Leon L. Gardner, and The Librarian, Mr. Wyllis E. Wright, to provide adequate space facilities and services to meet the public's need. Thus, it is hoped that the Army Medical Library will eventually be able to take its rightful place with the Folger Library and the Library of Congress on Capitol Hill. Only in this way can it meet the ever-increasing demands of medical progress.

#### IMPORTANT INFECTIONS IN CHILDREN

The common head cold is highly contagious and its complications may prove fatal. This is especially true in premature or immature infants and those suffering from nutritional disturbances. Diarrhea and dehydration have closed the scene in many cases that started as a simple head cold. In other cases the common cold may be re-

sponsible for impaired hearing later in childhood.

Individuals vary in their susceptibility to them but many are very susceptible, and in these individuals everything possible should be done to increase their resistance. Their nutrition should be maintained at as high a level as possible. They should be protected against chilling, but this does not mean coddling and overclothing as this procedure decreases rather than increases their resistance. The infant should be isolated from every individual with even the slightest cold. In the older child this is not practicable, but kissing should be prohibited. If the diet is well-balanced and contains adequate amounts of all of the essentials, stuffing with the vitamins will not influence the resistance of the patient in the slightest. Removal of foci of infection in the nose and throat may be of value in some cases. Vaccines may reduce the complications of the cold and thereby shorten the convalescence but it is doubtful if they influence the frequency of colds very much.

The more conservative the treatment the better. Local treatment should be such that it does not injure the mucous membranes of the respiratory tract. Saline or aqueous solutions of ephedrine, or its isomers, give much relief from congestion and allows the patient to get much needed rest. The sulfonamides are of value in treating such complications as pneumonia, otitis media and sinusitis but are of no value as far as the common cold is concerned.

In rheumatic heart disease, as in all illnesses, the most important thing is prevention. Once the heart is injured the best that can be done is to heal the injury as quickly as possible and prevent further damage. In many cases this is impossible.

As the majority of cases of rheumatic fever occur in the poor, improvement in the economic status of this class will do much to decrease the frequency of this disease. Where the child has adequate food and proper environmental surroundings, such as improved housing and proper medical supervision, the incidence of rheumatic fever decreases. Only when the state becomes cognizant of this fact and takes measures to



remedy it will there be much progress in its prevention.

Since infections in the nose and throat with hemolytic streptococci precede the majority of cases, measures should be taken to prevent their occurrence or to eradicate them as quickly as possible once they have occurred. Here proper nutrition, prevention of needless exposure and early medical care may pay handsome dividends.

In dealing with rheumatic infection the physician has to be familiar with its extremely variable manifestations. Here nothing can take the place of experience, though laboratory aids may be of incalculable value. The treatment of rheumatic fever has changed very little and is still largely symptomatic unless decompensation is present. The most important single measure is bed rest. It tends to protect the heart and should be employed in every case, however slight the symptoms, until all evidence of activity has subsided and for some weeks thereafter.

When cardiac decompensation is present absolute rest is imperative, and all efforts should be directed to this end. Digitalis in full therapeutic doses should be administered until the heart is completely digitalized. Then small transfusions of citrated whole blood should be given every few days. In our experience nothing has produced as marked improvement in these cases as has blood transfusions, and we employ them in all cases with anemia.

Rheumatic fever is apt to recur and these individuals should be under the care of a physician at all times. Periodic examinations will do much to prevent recrudescences which are likely to follow respiratory infections and some communicable diseases. Immunization should be employed where possible. Removal to warm climates, while beneficial, is not always possible, and since most of these patients will have to continue to live where they are it becomes necessary to try to improve the social and economic conditions in their homes. They have to be taught the indications for rest as well as the need for medical advice. All of their activities should be supervised and their vocation may have to be selected for them.

C. M. BURPEE, M. D.

*The author of this paper died before its publication*  
—Ed.

#### COUNTIES REPORTING FOR 1946

##### *Ben Hill County Medical Society*

The Ben Hill County Medical Society announces the following officers for 1946:

President—J. E. McMillan, Fitzgerald  
Vice-President—G. K. Cornwell, Fitzgerald  
Secretary-Treasurer—Francis O. Ward, Fitzgerald  
Delegate—W. D. Willcox, Fitzgerald  
Alternate Delegate—John E. Smith, Fitzgerald

##### *Georgia Medical Society*

The Georgia Medical Society, Chatham County, announces the following officers for 1946:

President—W. V. Long, Savannah  
Vice-President—J. E. Porter, Savannah  
Secretary-Treasurer—G. H. Johnson, Jr., Savannah  
Delegate—J. L. Elliott, Savannah  
Delegate—G. L. Touchton, Savannah

##### *Chattooga County Medical Society*

The Chattooga County Medical Society announces the following officers for 1946:

President—J. S. Williamson, Trion  
Vice-President—W. U. Hyden, Trion  
Secretary-Treasurer—W. B. Hair, Summerville  
Delegate—J. S. Williamson, Trion

##### *Decatur-Seminole Medical Society*

The Decatur-Seminole Medical Society announces the following officers for 1946:

President—W. L. Wilkinson, Bainbridge  
Vice-President—Wm. E. Whittle, Iron City  
Secretary-Treasurer—M. A. Ehrlich, Bainbridge  
Delegate—R. F. Wheat, Bainbridge  
Alternate Delegate—L. W. Willis, Bainbridge

##### *Fulton County Medical Society*

The Fulton County Medical Society announces the following officers for 1946:

President—Thos. P. Goodwyn, Atlanta  
Vice-President—Calvin B. Stewart, Atlanta  
Secretary-Treasurer—McClaren Johnson, Atlanta  
Delegates—L. M. Blackford, Atlanta  
A. O. Linch, Atlanta  
Lester A. Brown, Atlanta  
Joseph C. Massee, Atlanta  
C. W. Strickler, Jr., Atlanta  
Hugh Hailey, Atlanta  
Mark S. Dougherty, Atlanta  
W. A. Selman, Atlanta

##### *Gordon County Medical Society*

The Gordon County Medical Society announces the following officers for 1946:

President—G. T. Banks, Fairmount  
Secretary-Treasurer—J. E. Billings, Calhoun  
Delegate—W. D. Hall, Calhoun

##### *Grady County Medical Society*

The Grady County Medical Society announces the following officers for 1946:

President—A. B. Reynolds, Cairo  
Secretary-Treasurer—J. V. Rogers, Cairo  
Delegate—J. V. Rogers, Cairo

##### *Gwinnett County Medical Society*

The Gwinnett County Medical Society announces the following officers for 1946:

President—W. J. Hutchins, Buford  
Vice-President—D. C. Kelley, Lawrenceville  
Secretary-Treasurer—Sylvester Cain, Jr., Norcross  
Delegate—W. W. Puett, Norcross  
Alternate Delegate—D. C. Kelley, Lawrenceville

##### *Hancock County Medical Society*

The Hancock County Medical Society announces the following officers for 1946:

President—Horace Darden, Sparta  
Secretary-Treasurer—H. L. Earl, Sparta  
Delegate—C. S. Jernigan, Sparta  
Alternate Delegate—John D. Wiley, Sparta



# THE PRESIDENT'S PAGE

## OUR FIGHT IS NOT FINISHED

This is my last message as President of the Medical Association of Georgia. The overwhelming events of our personal and national lives during the two years of my encumbrance have made organization and professional matters secondary in our interest. First in our minds, night and day, have been the necessity of winning the war, and the responsibility on the home front of shouldering the work of the many doctors in the services. Then there was the waiting for them to get back, and for the unavoidable delay in the professional reconversion, with refresher courses, and what not. So that we are just now about ready to settle back into our normal schedules.

It is appropriate to say a few words of gratitude here to our comrades who were in the armed services, in behalf of the Medical Association of Georgia. The war is not yet far enough behind us to forget the terror and suffering that all but engulfed the world at the hands of inhuman invaders; nor the noble sacrifices of these, our doctors, who gave our Army, our Navy and other governmental agencies the best medical care of any war in history, and at the same time gave vast comfort to those of us at home who had loved ones in battle areas. Our thanks can mean little to them, but the expression of the love, pride and gratitude which swell in the hearts of each of us gratifies us, and we feel that we will find understanding in their hearts. Doctors manage generally to hide emotions, and think it indelicate to mention them. But a quiet contemplation of the past few years of hatreds, massacres, heroisms and sacrifices brings us to our knees, and we humbly pray never to have to send our youth into such a holocaust again—God grant it!

Large conventions were suspended for the

past two years, but district medical meetings have been held pretty generally. The fine type of programs presented and the warm spirit of friendliness found at these meetings inspired me with pride and confidence in the future of organized medicine. With our doctors back from battle and the war nine months behind us, we must now turn urgently to the problems that face our profession. The condition of the Medical Association of Georgia is healthy, and capable leaders have been put at the wheel of its affairs.

There has never before been as much legislation affecting medicine and hospitals; the threat of socialized medicine, though an old one, is more vigorous than ever; the Veterans' Administration is asking cooperation in the hospitalization and medical care of the veterans. Then there are other questions concerning our organization that hold high place in importance. These and other matters will come before the annual session of the delegates and general assembly at the Macon meeting May 7-10.

At no time in our history has it been as urgent as today for the individual physician to be active in behalf of the ideals which make the profession the boon to mankind that it has always been. It is the unawareness, or possibly lack of discernment, on the part of this same mankind that makes it necessary to head him off and save him from the dilemma which he is about to bring upon himself, and the doctor upon whom he depends.

It is, and has ever been, a distasteful fight but worth the price to us and the public. Let us gird ourselves for it!

CLEVELAND THOMPSON, M. D.

**THE JOURNAL**

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

APRIL, 1946

**THIOURACIL IN HYPERTHYROIDISM**

The management of patients with hyperthyroidism has been an interesting and engaging problem for many years. During the past few years many encouraging publications have been made regarding the use of thiouracil in hyperthyroidism.

Thiouracil has a very definite effect in lowering the basal metabolic rate in a toxic goiter patient. The clinical evidences of hyperthyroidism—fast pulse, loss in weight, nervousness, etc.—are clearly and unmistakably reduced to normal as the basal metabolic rate is lowered. This usually requires three to eight weeks. Just how permanent this reduction in metabolism may be, and how long a patient with hyperthyroidism can be maintained in this improved state with safety, remains a question. Along with this improvement the thyroid gland undergoes hyperplasia, is more friable, therefore more vascular, and is apt to bleed more freely than a gland that has undergone involutionary changes as it does following the administration of iodine.

While this drug is of decided aid in preparing patients with hyperthyroidism for operation, its use is not without danger; it may be a serious danger at times. Such mild reactions as nausea, vomiting, fever, edema and swelling of the submaxillary glands are without danger and will soon clear up after the drug is discontinued. Such serious condition as granulocytopenia or agranulocytosis makes the administration of this drug not to be taken too lightly. While thiouracil is being given the patient should be under careful observation. Blood studies should be made often so that the drug can be discontinued at any time any unfavorable blood changes develop.

With our present knowledge of this drug it is evident that it should not be given to the non-toxic goiter patient in preparation for the operation, or otherwise. It should

not be given to the mildly toxic patient, or to one that can be properly prepared with iodine. Its use should be limited to the extremely toxic patient, or to one refractory to iodine, or occasionally to one with cardiac involvement, or to one in whom surgery is contraindicated for one reason or another. When it is used iodine should be given ten days to two weeks before the operation is planned. It should be stressed that all other safeguards in the management of an extremely toxic goiter patient should be enforced as before the discovery and use of thiouracil.

Undoubtedly in the extremely toxic patient, with the proper administration of thiouracil, many bad risk patients can be operated on safely, many postoperative stormy reactions can be avoided and many two-stage procedures can be eliminated. Indeed, the discovery and proper use of thiouracil may be a definite step in controlling the toxic goiter patient without resorting to surgery.

BEN H. CLIFTON, M. D.

**GEORGIA MEDICAL SOCIETY  
TAKES STAND AGAINST THE  
SOCIALIZATION OF MEDICINE**

The Georgia Medical Society, founded in 1804 and the first medical society in our commonwealth, has taken steps to do its part against the plan to socialize medicine. Under date of March 18, 1946, its president, Dr. W. V. Long, and a special committee headed by two of its industrious members, Drs. John L. Elliott and Howard T. Exley, addressed the following communication to numerous people in Georgia and elsewhere.

Would it not be well if all other medical societies in our State followed the example of the Georgia Medical Society? Certainly such procedure would be helpful in informing our Senators and Representatives in the Congress of the United States.

"It is the consensus of opinion of the members of the Georgia Medical Society that socialization or any other form of regimentation of medical services administered from the national level is expensive, wasteful and time-consuming, ill-suited to the care of the sick in general and the medical emergency in particular. Such a program could not be administered in a democratic



manner pleasing to either the patient or the physician.

"The quality of service to the patient would be strained and inferior in the beginning and would deteriorate rapidly. Medical research would be curtailed, medical education would be static and medical progress in general would be set back two years for every single year such a program was in effect. That has been the experience in those countries where regimentation of medical services has been tried.

"The plan of Senators Wagner and Murray and Congressman Dingell is socialization of the most vicious sort and must be defeated. Their original bills were referred to the Senate Finance Committee and the House Ways and Means Committee. They have not been reported out, but after President Truman's message to Congress on November 19, 1945, Senators Wagner and Murray introduced a new bill, S.1606, in the Senate, and Congressman John Dingell introduced an identical bill, H.R. 4730, in the House of Representatives. These bills were shorn of some of the financial provisions making it possible to refer them to committees more sympathetic. For example, S. 1606 was referred to the Committee on Education and Labor of which committee Senator Murray is chairman. These bills will undoubtedly be reported out of committee and probably at an early date. When reported out, they will have the very strong support of the CIO and other well organized groups which may make their defeat most difficult. We are informed that the Y. W. C. A. in national session at Atlantic City two weeks ago went on record as favoring such legislation.

"The Georgia Medical Society is gravely concerned about such trends and unalterably opposed to such legislation. Several months ago a committee was appointed to meet with similar committees from the dentists, lawyers, pharmacists, retail credit men, realtors, medical auxiliary, pharmacists' auxiliary, nurses and others to seek ways and means of opposing socialistic trends in national government and to seek ways and means of curing those ills which foster such trends.

"We have met with enthusiastic cooperation from the other groups and have learned much and accomplished much in our first few meetings. We have organized and solidified our home front and have sent to our Senators and Congressmen more than twelve hundred letters from the citizens of Savannah, letting them hear at long last the voice of our stratum of society, a voice too long silent in this country. We feel confident that organization of these groups can be accomplished in every county, parish and state of this great nation and the letters of protest pouring by the millions into Washington can save for us that freedom of thought and action for which our ancestors bled and died."

## JOURNAL SAYS BRITISH HEALTH PLAN WILL ENSLAVE MEDICINE

*Editorial Charges Proposal Is Backward Step And Makes Every Physician A "Clock-Watching Civil Servant"*

*The Journal of the American Medical Association* says that England's recently announced socialized health plan "will be considered by representatives of medical science everywhere as one of the most backward steps ever conceived for a civilized nation."

In an editorial appearing in the March 30 issue, *The Journal* says:

Regardless of the preliminary publicity and the prolonged incubation period, the announcement of the proposal for the nationalization of medical services in Great Britain was startling. Apparently the British government proposes to take over—in every sense of those words—the hospitals and the medical practices of British physicians. Thus a nation which fought to a successful issue against totalitarianism now proposes to enslave its own medical profession and to make of every one of its physicians a clock-watching civil servant. Men who formerly devoted their lives wholeheartedly to the care of the sick and to the relief of pain and suffering will now be spending their hours trying to satisfy the whims of the bureaucrats and to disencumber themselves from the red tape the bureaucrats inevitably weave. What the government leaders urge as a step forward in the prevention and control of disease will be considered by representatives of medical science everywhere as one of the most backward steps ever conceived for a civilized nation.

In an address on "The Science and Art of Medicine" delivered by Sir Lionel Whitby as his inaugural lecture as regius professor of physic in Cambridge University, the distinguished British physician said:

The simple facts are that medicine is both a science and an art. It is true that medicine will never be an exact science, because the normal variations in individuals have such a wide range that automatic and mechanical treatment is prohibited, whilst every patient requires a different method of approach according to his psychology. This, the frequently ridiculed bedside manner, which secures the confidence of the patient, is of fundamental importance in practice; it is an art which is inborn and not acquired. Nevertheless, even the most confirmed artist cannot now neglect to keep up to date with the facts and findings of science upon which his diagnosis and treatment must be based. Nor will the artistic claim be very sympathetically received by a court of law, should the claimant have neglected the scientific aspect. But one of the attractions of the profession is the personal and individual character of its practice: the latitude with which



a qualified doctor may exercise his own judgment, express his own opinions and practice his own art. *This, indeed, is one of the strongest objections to nationalization and standardization. If the profession of medicine be robbed of its scope for individuality, the soul will go out of it (italics ours).*

Thus from a British leader comes new emphasis on the points that great American physicians have emphasized in their opposition to socialized or political medicine.

During the great war just ended scientific medicine advanced tremendously. The development of the antibiotic drugs, of blood derivatives, of new surgical technics, of controls over insect borne diseases are among the steps that will increase life expectancy and even perhaps reduce the incidence of such diseases as pneumonia and the venereal diseases, as typhoid and diphtheria have been decreased. In the face of constant advancement and ever diminishing morbidity and mortality the politicians would promote a revolution in methods of medical education, medical research and medical care, unthinking that the steps they propose may halt if not destroy the scientific medical forces that have yielded these results.

Especially sad is the British proposal that the government take over the private hospitals which have been the pride of the democracies for more than a century. Our Catholic, Protestant and Jewish hospitals have grown out of that fundamental tenet of all great religions that the care of the sick is one of the highest spiritual motives to which man can attain. Britain's act proposes that these hospitals become creatures of an automatic routine ridden government bureaucracy. Thus sick human beings would become cards in a government index representing robots, which when incapacitated, would receive the ministrations of employed doctors reduced to the status of subservient mechanics.

Perhaps the long controversial debate to which this arbitrary and revolutionary legislation is certain to be subjected in the British Parliament will develop some means for retaining in Great Britain the spirit and the tradition that have earned for British medicine up to now the respect of scientists throughout the world.

### CONVALESCENT SERUM AND PENICILLIN BEST FOR SCARLET FEVER

A Navy physician has found that simultaneous injections of human convalescent scarlet fever serum and penicillin provide the best means for treating scarlet fever.

Lieut. Comdr. Paul Ashley (MC), U.S.N.R., writing in the March 23 issue of *The Journal of American Medical Association*, says that within 24 hours after the appearance of the rash the patients should have convalescent scarlet fever serum injected into their veins and 30,000 units

of penicillin injected into the muscles. Thereafter, they should receive 15,000 units of penicillin every three hours until their temperature has remained normal for five days.

Comdr. Ashley states that the patients responded to this treatment better than that of any other tried, regardless of the severity of the illness.

The blood serum comes from patients who are convalescent from scarlet fever and, when introduced into the body, it produces immunization by virtue of the antibodies which it contains. These antibodies are specific substances which react against an invading micro-organism.

Comdr. Ashley's report was based on 298 patients who were studied in groups of approximately 50 to compare different types of treatment.

The author says that from 50 to 60 per cent of the cases of scarlet fever observed were caused by certain types of group A beta-hemolytic streptococci which are resistant to the sulfonamides. Therefore, the author cautions against the use of sulfadiazine in the treatment of such patients.

### TELECAST A. M. A. HEALTH PROGRAMS OVER CHICAGO STATION FOR 26 WEEKS

The Bureau of Health Education of the American Medical Association will sponsor a series of experimental telecasts on WBKB, Chicago, beginning April 2 and running for 26 weeks.

"Television should be a particularly useful medium for the demonstration type of educational program," W. W. Bauer, M.D., director of the bureau, said. "Television makes possible demonstration and exhibit, appealing both to the visual and to the auditory pathways to the brain. Procedures difficult to describe by word of mouth alone can be visually demonstrated by bringing before the camera such procedures as the taking of blood pressure, bandaging, first aid, blood counting and the use of x-rays."

The following subjects will be shown:

April 2—Evolution of the stethoscope by Edwin P. Jordan, M.D., associate editor of *The Journal of the American Medical Association*.

April 11—Medical Uses of the X-ray by H. A. Carter, secretary of the A. M. A. Council on Physical Medicine.

April 25—The Basal Metabolic Rate by W. W. Bolton, M.D., of the Bureau of Health Education of the A.M.A.

May 9—Blood Examination by J. J. Moore, M.D., Chicago, Treasurer of the A.M.A.

May 23—Blood Pressure Demonstration by Dr. Jordan.

June 6—Contagious Disease Precautions in the Home by Dr. Bauer.

June 20—Methods of administering Drugs by Austin E. Smith, M.D., Secretary of the Council on Pharmacy and Chemistry of the A.M.A.

The script is being prepared by Felice Kerrigan of the Balaban & Katz television staff in cooperation with each medical demonstrator and the Bureau of Health Education. Gladys Lundberg also of the WBKB staff, is the producer-director of the series.

While the television audience in the Chicago area is limited, Dr. Bauer said it is believed the programs will prove the efficacy of television in conveying important messages of health and good living to the general public in a new manner. "Methods and techniques," he said, "can be developed so that the medical profession will be ready in the future to make use of this new medium as it has used older mediums, such as the radio and the printed page, effectively."

**WOMAN'S AUXILIARY**

President—Mrs. W. T. Randolph, Winder.  
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.  
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.  
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.  
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

**OFFICERS 1944-46**

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.  
 Corresponding Secretary—Mrs. Alex Russell, Winder.  
 Treasurer—Mrs. Ralph Fowler, Marietta.  
 Historian—Mrs. W. W. Puett, Norcross.  
 Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.  
 Press and Publicity—Mrs. Charles Daniel, College Park.

**AUXILIARY NEWS**

The Auxiliary to the Georgia Medical Society met at the home of Mrs. E. N. Maner in Savannah February 8. Minutes of the previous meeting were read and approved. Treasurer's report showed a balance on hand of \$139.63. Mrs. E. N. Gleaton, chairman of Research and Romance in Medicine, presented a paper on the life of Dr. E. R. Corson. Mrs. W. R. Dancy reported a total of 56 subscriptions obtained for *Hygeia*. Mrs. John L. Elliott reported the participation of the medical auxiliary in the dental survey and also in the street sale of T. B. bangles. Mrs. S. F. Rosen, chairman of Doctors' Day, stated Doctors' Day would be celebrated with an informal cocktail party to be given at the home of Mrs. R. L. Neville. Mrs. S. Elliott Wilson was appointed chairman of sandwiches; Mrs. Arthur Morrison, Jr., to write the Doctors' Day poem and the invitations for the occasion; Mrs. Charles Usher to be in charge of the editorial and the radio talk. Several visitors were welcomed. The following workers were appointed to serve in the cancer campaign in April: Mrs. C. Y. Bailey, Mrs. H. M. Kandel, Mrs. E. Ham, Mrs. G. H. Lang, Mrs. S. F. Rosen, Mrs. William Lattimore, Mrs. H. H. McGee, Mrs. Lee Howard, Mrs. R. L. Neville, Mrs. C. R. A. Redmond, Mrs. Hugo Johnson, Jr., Mrs. S. E. Wilson, Mrs. Charles Usher.

The following nominating committee was elected:

Mrs. Lee Howard, Chairman  
 Mrs. H. H. McGee  
 Mrs. Ralston Lattimore  
 Mrs. R. V. Martin

Mrs. Charles Usher's resignation as president-elect was read and accepted with regret. Members were reminded that the state convention would be held in Macon May 7-10, and that those expecting to attend should make reservations.

\* \* \*

Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, was the speaker at a recent meeting of the Woman's Auxiliary to the Richmond County Medical Society in Augusta. He discussed the undesirable aspects of the Wagner-Murray-Dingell bill for socialized medicine. The meeting was held at the home of Mrs. Eugene Matthews, with Mrs. W. A. Wilkes

as co-hostess.

The auxiliary has adopted as its project the supplying of bathrobes for the pediatric work of the University Hospital and 10 new bathrobes were turned in at Tuesday's meeting.

Following the business meeting, refreshments were served. The table was covered with a white cut-work linen cloth with pink camellias and baby's breath spirea as a central decoration.

\* \* \*

The election of officers featured the meeting of the Barrow County Medical Auxiliary, which met at the home of Mrs. W. T. Randolph in Winder recently. The following slate of officers was elected and will serve for the ensuing year:

President—Mrs. W. T. Randolph  
 1st Vice-President—Mrs. S. T. Ross  
 2nd Vice-President—Mrs. C. B. Almand  
 Recording Secretary—Mrs. E. R. Harris  
 Corresponding Secretary—Mrs. A. B. Russell  
 Treasurer—Mrs. Quentin Randolph  
 Historian—Mrs. Ralph Freeman  
 Parliamentarian—Mrs. E. M. McDonald

Mrs. C. B. Almand, vice-president, conducted the business session in the absence of Mrs. A. B. Russell, president. Plans were made for the observance of Doctors' Day. Mrs. C. B. Almand and Mrs. E. R. Harris were elected delegates to the state convention which convenes in Macon. Mrs. W. T. Randolph was appointed a member of the Better Home Towns Committee currently sponsored by the Georgia Power Company.

Prior to the business session, Mrs. Randolph entertained at a beautifully appointed luncheon with covers placed for Mesdames S. T. Ross, Mrs. E. M. McDonald, C. B. Almand, Ralph Freeman, Quentin Randolph and E. R. Harris. The Randolph home was beautifully decorated with a profusion of early spring flowers.

\* \* \*

Members of the Fulton County Medical Society were honored at a reception on Saturday evening, March 30, from 8 to 10 p. m., at the Academy of Medicine on West Peachtree Street, with the Woman's Auxiliary as hostess. The occasion, held on Doctors' Day, was in compliment to the new officers of the society and to the members who have recently returned from service in the armed forces.

(Continued on page 131)



## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lil-lye W. Goodrum Geeslin, 1008 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, WALnut 8911; residence, JACKson 7979.



Poster Contest for Nurse Recruitment—Left to right, Mrs. Durice Hanson, executive secretary of the State Nursing Council; Miss Charity Wells, president of the Fifth District of the Georgia Nurses' Association; and Mrs. J. N. Brawner, Sr., Co-chairman of the Student Nurse Recruitment Com-

mittee, discuss plans for a state-wide nursing education poster contest with Dr. M. D. Collins, superintendent of Georgia schools. Prizes will be given for the best posters on the subject of nursing education or nursing service by the State Nursing Council.

### GEORGIA STATE-WIDE NURSING POSTER CONTEST

Sponsored by the Recruitment Committee, State Nursing Council

131 Forrest Ave., N.E., Atlanta.

#### RULES AND REGULATIONS

*Purpose:* Posters on nursing education and

nursing service to be used throughout state to interest qualified young women in selecting nursing as a profession.

*Beginning Date:* March 15, 1946.

*End of Contest:* May 1, 1946.

*Who Qualifies and How:*

Junior and senior high school students.



College students or graduates of high school or college.

Young veterans or others with high school education.

Age: 16-35 Years.

Note: Professional artists are not admitted to this contest.

Note: The Art Departments, Health Education and Home Economics Divisions of schools are especially requested to interest students in entering the contest.

**HOW TO ENTER CONTEST:** Secure and fill out application form for entrance to contest and mail to president of district or chairman of your nearest district recruitment committee. The following is a list of the district presidents:

#### District

- 1—Lucy M. Hall, 522 E. 40th St., Savannah
- 2—Mrs. Paul Davis, Thomasville
- 3—Mrs. Elizabeth Hart, 2010 Summerville Rd., Phoenix City, Ala.
- 4—Elizabeth McClellan, Strickland Hospital, Griffin
- 5—Charity Wells, 2080 N. Decatur Road, Atlanta
- 6—Mrs. Irma S. Marsh, State Hospital, Milledgeville
- 7—Mrs. T. E. Booz, 213 E. 10th St., Rome
- 8—Mrs. Joan Drumps, 2919 Dartmoor Homes, Brunswick
- 9—Mrs. Russell Chamblee, 320 E. Washington, Gainesville
- 10—Mrs. Effie R. Akerman, 831 15th St., Augusta
- 11—Mrs. Warren Thurmond, 66 Prince Place, Athens
- 12—Mrs. L. D. Flahive, Sumter Health Dept., Americus
- 13—Louise Abercrombie, Millen

#### Prizes:

Each district or recruitment committee will offer a 1st., 2nd., and possibly 3rd prize.

The Winner of the 1st. Prize in District Contest competes for State Prize—1st., 2nd., and possibly 3rd. Prize will be offered by State Program.

#### Where Prizes Are To Be Awarded:

At school graduation, assembly or other special program arranged by district or state recruitment committees.

Size of Posters: Approximately 19"x24".

Type Poster Material: Use material easiest to secure.

#### Display of Posters:

Just as soon as person is admitted to contest and poster is completed, the poster is to be displayed in a conspicuous and public spot to attract attention. Either in schools, libraries, post office, railroad or bus stations or any suitable display window.

The name of artist should not appear on poster before prizes are awarded.

#### Judges:

Judges will be selected by each district recruitment committee and the state judges will be selected by the state committee.

Judges will be selected from: art, health education and home economics departments, medical and nursing profession, public health, hospital, welfare, general education and from government groups.

Men and women will be selected as judges.

The list of judges will be announced by each district and by the state recruitment committee.

**Where to Secure Information On Nursing Education and Nursing Service:**

1. State Nursing Headquarters, 131 Forrest

Ave., N.E., Atlanta.

2. Your nearest school of nursing.

3. Your public library.

4. Nursing information bureau American Nurses' Association and The National League of Nursing Education, 1790 Broadway, New York 19, N. Y.

5. National Nursing Council, 1790 Broadway, New York 19, N. Y.

Write for publication lists and free pamphlet on nursing.

Refer to medical, hospital and health magazines for illustrations and possible suggestions.

### AUXILIARY NEWS

(Continued from page 129)

Mrs. D. R. Longino, president of the auxiliary, was official hostess. In the receiving line with her were Dr. Longino, Dr. Thomas P. Goodwyn, president of the society, and Mrs. Goodwyn; Dr. Hugh Wood, president-elect; Dr. Calvin Stewart, vice president, and Mrs. Stewart; Dr. McClaren Johnson, secretary-treasurer, and Mrs. Johnson; Dr. Don Cathcart, chairman of the board of trustees, and Mrs. Cathcart; Dr. J. Harry Rogers, chairman of the advisory committee to the auxiliary, and Mrs. Rogers.

Receiving the guests at the door were Mrs. Olin S. Cofer, immediate past president of the Woman's Auxiliary to the Medical Association of Georgia, and Mrs. John W. Turner, immediate past president of the Woman's Auxiliary to the Fulton County Medical Society. Presiding at the two punch bowls were Mrs. Eustace A. Allen, first vice president of the Woman's Auxiliary to the American Medical Association; Mrs. Hal M. Davison, president-elect of the Fulton County group; Mrs. Edgar H. Greene, first vice president of the Woman's Auxiliary to the Medical Association of Georgia, and Mrs. B. L. Shackelford, president of the Woman's Auxiliary to the Fifth District Medical Society.

Mrs. Harry Rogers was chairman for Doctors' Day, with Mrs. Shelley Davis, co-chairman. Assisting them were Mrs. John Funke, house chairman; Mrs. Dewey Nabors, decorations; Mrs. W. M. Dunn, entertainment, and Mrs. F. C. Holden, courtesy.

### IRON DEFICIENCY ANEMIA MISTAKEN FOR VITAMIN B COMPLEX DEFICIENCY

Iron deficiency anemia is frequently confused with vitamin B complex deficiencies, according to William J. Darby, M.D., of Nashville, Tenn., writing in the March 30 issue of *The Journal of the American Medical Association*.

Dr. Darby, who is from the Department of Medicine, Vanderbilt University School of Medicine, presents the case reports of six patients who showed no abatement of symptoms after treatment with B vitamins. These same patients were then treated with iron and almost immediate improvement was noted.

Iron is a necessary part of hemoglobin, the red coloring matter of the blood. The symptoms of iron deficiency are manifested by a mild anemia, inflammation of the tongue and sometimes an inability to swallow. Iron deficiency anemias are more common among women than men.

## GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

## LIMITATIONS OF ANTIRABIC TREATMENT

No one dares question the prophylactic efficiency of antirabic treatment in protecting persons really bitten by rabid animals. True, some virus authorities have in recent years whispered a bit of skepticism behind the barn, so to speak. Certainly it fails in some instances. But it does produce definitely measurable antibodies, both in experimental animals and in man. We no longer have the opportunity of determining what the natural mortality rate of rabies would be without treatment for very obvious reasons. So we must still rely on the estimates of writers prior to Pasteur's time, which ranged from 5 to 15 per cent. When we compare these rates with our present day average of less than 1 per cent mortality in treated cases, we are forced to concede the value of antirabic vaccine.

Therefore, when a physician is confronted with a patient who has actually been bitten by an animal known or suspected to be rabid, he is justified in giving antirabic vaccine promptly and without hesitation.

If, however, the physician is satisfied that his patient has not been bitten but only "exposed" by getting the saliva on the bare skin, or even in contact with pre-existent abrasions, or by handling the animal—in short, by any method other than a break or penetration of the skin by the teeth of the animal—he should not advise antirabic treatment.

Does this mean that there is no risk involved in any exposure other than teeth wounds? Theoretically no, but from a practical standpoint it means just that. Most text writers advocate prophylactic treatment for a variety of exposures other than bites, such as claw scratches, bites through untorn clothing, getting saliva on the skin, or in contact with abrasions, etc. But those of us who have opportunity to study and closely observe the cycle of events from beginning to end of many thousands of rabies exposure cases over a long period of time; to study the human fatalities and the reactions and complications of treatment, cannot escape the conclusion not only that the infectiousness of man to rabies has been greatly over-rated, but that antirabic treatment of itself may be more dangerous than the disease under circumstances of exposure other than actual tooth wounds.

During the past 20 years (1925-1945) we have recorded and studied 61 human deaths from rabies in Georgia. During this period 45,994 received antirabic vaccine. Thirty-two of the 61 were post-treatment deaths. Thus the post-treatment death rate was 0.7 per cent. In no in-

stance did the disease develop in persons known not to have been bitten.

In regard to the 32 post-treatment deaths, the relative seriousness of face wounds is impressive. The death rate per 1,000 persons bitten on the face was 7.91 as compared to 0.50 for bites on the hands, and 0.11 for bites on the feet and legs. Thus bites on the face are 16 times more dangerous than on the hands, and 72 times more dangerous than on the legs.

Beginning in 1937, we instituted the policy of advising a precautionary treatment of only 12 injections of vaccine for persons whose exposure was less than an actual break in the skin by the teeth. More than 7,500 such *precautionary* treatments had been recorded by the end of 1945. No deaths have occurred. During this same period 144 were given the *drastic* treatment, of 3 doses daily for 15 days, for severe bites about the face and head, and 6 died of rabies. Of 1,075 persons receiving the *intensive* treatment, 2 doses daily for 10 days followed by 11 daily injections, for slight face wounds or severe hand wounds, 10 died of rabies. Of 11,422 receiving the *mild* treatment, of one daily dose for 21 days, for moderate or mild wounds anywhere on the body except the face or head, 15 died of rabies. In all there were 31 deaths among 12,641 persons treated for actual bites, as compared with no deaths in 7,511 treated for all other kinds of exposure. From these facts alone the conclusion is warranted that all exposures other than tooth wounds should be disregarded.

The physician, however, often needs more than statistical logic to cope with the psychological problem. So steeped is the average person in traditional fear and horror of rabies, born of exaggerated misconceptions of its infectiousness, that often nothing short of treatment will bring peace of mind to those even remotely exposed. On the assumption that the vaccine is harmless, the physician frequently feels justified in treating for protection against rabiphobia, rather than hydrophobia.

Unfortunately, antirabic vaccine is not entirely harmless. A complication known as treatment paralysis has long been recognized. Marie Remlinger and Vallée at the International Rabies Conference in Paris in 1927, reported 329 cases of treatment paralysis among 1,164,264 persons treated, or roughly 1 per 3,000. While the majority recover, this malady at best is a serious one. The mortality ranges from less than 10 per cent in the simple neurotic type to as high as 30 to 40 per cent in the encephomyelitic type.

While there is still some conflict of opinion as to its etiology, the prevailing belief at present is



that it is an allergic phenomenon brought about by specific sensitization to rabbit brain tissue proteins. Some observers even go further in claiming that other forms of allergy predispose to treatment paralysis. As will be emphasized in citing our experience in Georgia, repetition of treatment is definitely a predisposing factor.

There are two types of reaction to antirabic vaccine now well recognized. The first consists of local and generalized skin reactions, such as may develop after repeated injections of a variety of foreign proteins, e. g., bacterial vaccines and antisera. These are rarely serious and do not as a rule contraindicate continuation of treatment. The second type consists of neurologic reactions, with which we are concerned in this discussion.

Since 1925 we have encountered 7 cases of treatment paralysis among approximately 50,000 persons treated in Georgia—a ratio of one in 7,000. Four of the 7 were fatal. Five occurred in persons who had previously received treatment, a frequency which is beyond the realm of mere chance. In all cases the onset ranged from 12 to 20 days after the first injection. The following is a typical example.

Mrs. E. B., aged 35, was bitten by a rabid dog in July 1935, and received 21 injections of antirabic vaccine without untoward reactions. Thirty months later she was again indirectly exposed, and against the advice of the local county health officer, insisted on re-treatment. A few hours after the 12th injection she noted a numbness of her fingers and toes and backache. Two days later she became paralyzed in all extremities, as well as her body, although there was at this time no involvement of the cranial nerves, or of cardiorespiratory function. On the 5th day after onset she was conscious, mentally rational, and able to take food. Later during the 5th day she suddenly became cyanotic and dyspneic. Stimulants failed to relieve her and she died of respiratory failure.

In another case, observed in 1925, paralysis rapidly involved the entire body as well as the cranial nerves, but after 10 days functional recovery occurred in reverse order. This patient also had been previously treated, and had received the 12th dose of re-treatment when the paralysis began. A more detailed description of all seven cases will be published later.

### *Comments and Conclusions*

While antirabic treatment is fully justified for persons known or suspected to have been bitten by rabid or suspicious animals, it cannot be regarded as harmless. For all exposures other than actual tooth wounds the danger of treatment reactions is greater than that of rabies.

Extreme caution should be exercised in treating persons who at any time have received previous treatment. Even for severe wounds, re-treatment should be given very cautiously and probably for only 5 or 6 days as a "booster" to the immunity mechanism established by the previous treatment. At the slightest sign of systemic reaction, such as headache or fever, or tingling sensations, treatment should be stopped immediately. Even marked local reactions should be regarded with suspicion.

Finally, for all exposures other than actual bites, antirabic treatment should be strongly discouraged, and under no circumstances should such exposures be re-treated.

T. F. SELLERS, M. D.

## COUNTIES REPORTING FOR 1946

### *Jefferson County Medical Society*

The Jefferson County Medical Society announces the following officers for 1946:

President—J. J. Pilcher, Wrens  
Vice-President—C. Roy Williams, Wadley  
Secretary-Treasurer—J. W. Pilcher, Louisville

### *Lamar County Medical Society*

The Lamar County Medical Society announces the following officers for 1946:

President—D. W. Pritchett, Barnesville  
Vice-President—J. H. Jackson, Barnesville  
Secretary-Treasurer—S. B. Traylor, Barnesville  
Delegate—J. A. Corry, Barnesville

### *Laurens County Medical Society*

The Laurens County Medical Society announces the following officers for 1946:

President—J. A. Bell, Jr., Dublin  
Vice-President—Fred J. Coleman, Dublin  
Secretary-Treasurer—O. H. Cheek, Dublin  
Delegate—R. G. Ferrell, Jr., Dublin  
Alternate Delegate—W. H. Bedingfield, Rentz

### *Montgomery County Medical Society*

The Montgomery County Medical Society announces the following officer for 1946:

Secretary-Treasurer—J. W. Palmer, Ailey

### *Newton County Medical Society*

The Newton County Medical Society announces the following officers for 1946:

President—W. D. Travis, Covington  
Secretary-Treasurer—J. B. Mitchell, Jr., Porterdale  
Delegate—W. D. Travis, Covington  
Alternate Delegate—W. J. Huson, Covington

### *Rockdale Medical Society*

The Rockdale County Medical Society announces the following officers for 1946:

Secretary-Treasurer—H. E. Griggs, Conyers  
Delegate—H. E. Griggs, Conyers  
Alternate Delegate—P. J. Brown, Conyers

### *Sumter County Medical Society*

The Sumter County Medical Society announces the following officers for 1946:

President—A. C. Primrose, Americus  
Vice-President—J. C. Logan, Plains  
Secretary-Treasurer—R. H. Enzor, Smithville  
Delegate—R. C. Pendergrass, Americus  
Alternate Delegate—L. S. Boyette, Ellaville

### *Telfair County Medical Society*

The Telfair County Medical Society announces the following officers for 1946:

President—W. H. Born, McRae  
Vice-President—C. J. Maloy, McRae  
Secretary-Treasurer—F. R. Mann, McRae  
Delegate—S. T. Parkerson, McRae  
Alternate Delegate—C. J. Maloy, McRae

### *Thomas County Medical Society*

The Thomas County Medical Society announces the following delegates for 1946:

Delegate—Ernest F. Wahl, Thomasville  
Alternate Delegate—George R. Dillinger, Thomasville

### *Tri-County Medical Society*

The Tri-County Medical Society, Calhoun, Early-Miller, announces the following officers for 1946:

President—S. P. Holland, Blakely  
Vice-President—C. K. Sharp, Arlington  
Secretary-Treasurer—J. G. Standifer, Blakely  
Delegate—J. G. Standifer, Blakely  
Alternate Delegate—W. C. Hays, Colquitt

*Tri-County Medical Society*

The Tri-County Medical Society, Liberty-Long-McIntosh, announces the following officers for 1946:

Secretary-Treasurer—O. D. Middleton, Ludowici  
Delegate—I. G. Armistead, Fine Harbor

*Turner County Medical Society*

The Turner County Medical Society announces the following officers for 1946:

President—W. J. Turner, Ashburn  
Secretary-Treasurer—J. H. Baxter, Ashburn  
Delegate—J. H. Baxter, Ashburn

*Walton County Medical Society*

The Walton County Medical Society announces the following officers for 1946:

President—Charles S. Floyd, Loganville  
Vice-President—Phillip R. Stewart, Monroe  
Secretary-Treasurer—Lynn M. Huie, Monroe  
Delegate—Charles S. Floyd, Loganville  
Alternate Delegate—Phillip R. Stewart, Monroe

*Warren County Medical Society*

The Warren County Medical Society announces the following officers for 1946:

President—H. B. Cason, Warrenton  
Vice-President—F. L. Ware, Warrenton  
Secretary-Treasurer—A. W. Davis, Warrenton  
Delegate—A. W. Davis, Warrenton  
Alternate Delegate—F. L. Ware, Warrenton

*Taylor County Medical Society*

The Taylor County Medical Society announces the following officers for 1946:

President—F. H. Sams, Reynolds  
Vice-President—S. H. Bryan, Reynolds  
Secretary-Treasurer—R. C. Montgomery, Butler  
Delegate—Lewis Beason, Butler

*Greene County Medical Society*

The Greene County Medical Society announces the following officers for 1946:

President—Goodwin Gheesling, Greensboro  
Vice-President—W. H. Lewis, Siloam  
Secretary-Treasurer—Franklin H. Killam, Greensboro  
Delegate—Franklin H. Killam, Greensboro

*Cherokee-Pickens Medical Society*

The Cherokee-Pickens Medical Society announces the following officers for 1946:

President—J. T. Pettit, Canton  
Vice-President—E. A. Roper, Jasper  
Secretary-Treasurer—R. T. Jones, III, Canton  
Delegate—C. R. Andrews, Canton  
Alternate Delegate—John R. Lewis, Canton

## NEWS ITEMS

The Bibb County Medical Society held its monthly meeting at Ridley Hall, Macon, March 5. Dr. Hall Farmer was in charge of the program.

Dr. Charles Andrews, Canton, recently discharged from the United States Navy, has joined the hospital staff of physicians at Coker Hospital, Canton.

Dr. John T. Akin, Jr., Atlanta, announces the removal of his offices to 35 Fourth St., N. E., Atlanta (between the Peachtrees). Practice limited to general surgery.

Dr. William E. Brown, formerly of Greensboro, recently discharged from the Medical Corps of the U. S. Army, announces the opening of his office in the Brannon Building, Dawson, for the practice of medicine.

Dr. Taylor S. Burgess, Atlanta, announces his release from the United States Navy, and return to the practice of medicine, 310 Medical Arts Building, Atlanta. Diseases of the ear, nose and throat.

Dr. W. D. Cagle, formerly of Griffin, recently assumed his duties as Whitfield County public health commissioner. He succeeds Dr. Charles Engleking, who resigned last fall. Dr. Cagle is employed under a joint city-county program and will make his home at Dalton.

Dr. Robert W. Candler, Atlanta, announces the re-opening of his offices for the practice of surgery, 490 Peachtree Street, N. E., Atlanta.

Dr. Zack S. Cowan, Atlanta, announces his retirement after 29 years' practice of medicine and surgery. Dr. Cowan will make his home in Clearwater, Fla.

Dr. James B. Craig, formerly of Ann Arbor, Mich., recently released from the Medical Corps of the U. S. Army, announces the opening of his offices at Savannah, for the practice of neuropsychiatry.

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the dining room, March 14. The program for the evening was, "Diagnosis and Treatment of the Acute Surgical Abdomen, With Illustrative Cases."

Dr. Daniel C. Elkin, Atlanta, recently delivered the principal address at the annual Alpha Omega Alpha banquet, Nashville, Tenn. He addressed the honorary medical fraternity's banquet on, "Arteriovenous Fistula Effects on the Circulation." Dr. Elkin was recently elected president of the Southern Surgical Association.

Dr. Murdock Euen, Atlanta, recently presented "The Magnetic Removal of Foreign Bodies from the Food and Air Passages" before the Southern Section of the Triological Association in Richmond, Va.

Dr. George L. Epps and Dr. J. P. Tucker, Bainbridge, both recently discharged from the Medical Corps of the U. S. Army, announce the opening of offices for the practice of medicine at Bainbridge. Dr. Epps is building a professional office at 402 West Street, and Dr. Tucker is associated with Drs. Gordon Chason, R. F. Wheat and W. L. Wilkinson, and the Riverside Hospital, Bainbridge.

Dr. Albert L. Evans, Atlanta, after serving four years in the Army Medical Corps with foreign service in Europe, is now associated with Dr. Olin S. Cofer, 478 Peachtree Street, N. E., Atlanta, in the practice of surgery and gynecology.

The Georgia Baptist Hospital, Atlanta, staff dinner meeting was held in the nurses' home dining room, March 19. Dr. C. E. Rushin was in charge of the program.

Dr. C. A. Henderson, Savannah, city-county health officer, recently discussed the mass survey of syphilis and tuberculosis in Chatham County at the conference of the Georgia Social Hygiene Council in Atlanta.

Dr. Arthur W. Hill, Thomasville, recently discharged from the Medical Corps, U. S. Army, has taken charge of the Thomas-Grady counties health unit. Thomas County is to have five nurses and a sanitarian; Grady County is to have four nurses and one sanitarian. There is to be a supervisor of nurses. At present the staff cannot be completely filled because of the shortage of personnel.

Dr. Fred G. Hodgson, Atlanta, long chairman of the department of orthopedics in Emory University School of Medicine, has resigned and has been named professor emeritus. He is a member of the American Orthopedic Association, American Academy of Orthopedic Surgery, American Board of Orthopedic Surgeons, American College of Surgeons, American Medical Association and the Medical Association of Georgia.

Dr. George A. Holloway, Atlanta, announces the re-opening of his office, 33 Ponce de Leon Ave., N. E., Atlanta. Obstetrics and gynecology, by appointment only.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, March 7. Program: Clinical talk—"Nebulization in Chronicity," Dr. A. Worth Hobby; Paper—"Treatment of Aneurysm and Arterial Venous Fistula," Dr. Daniel C. Elkin.



Dr. Lester A. Brown, Atlanta, is taking a six weeks course with Dr. Julius Lempert, Lempert Institute of Otolaryngology, New York, and will resume his practice in Atlanta on April 15.

Dr. Ralph Johnson, Rome, recently released after more than three years' service with the Army Air Force, has resumed his association with McCall Hospital, Rome.

Dr. B. H. Minchew and Dr. Braswell Collins, Waycross, have resumed their association following the return of Dr. Collins from the armed forces. Practice limited to diseases of the eye, ear, nose, and throat.

The Clarke-Madison-Oconee Medical Society held its monthly meeting at Athens, February 28. Program: "Physiology of Labor," Dr. Richard Torpin, Augusta.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, January 8. Paper: "Trends in Chest Surgery," Dr. Robert Major, Augusta.

Emory University School of Medicine, Atlanta, announces the promotion of four Atlanta physicians. The promotions, approved by the university executive committee at its February meeting, are: Dr. James Mason Baird from assistant to associate professor of clinical ophthalmology; Dr. Chester A. Fort, Jr., from instructor to associate in urology; Dr. Charles A. Eberhardt from assistant to associate in urology, and Dr. William B. Armstrong from instructor to associate in clinical otorhinolaryngology.

The following doctors have been added to the faculty: Dr. Wm. H. Galvin, assistant professor of surgery; Dr. Frederick W. Cooper, Jr., associate in surgery; Dr. M. F. Fowler, associate in urology; Dr. Charles Reiser, associate in urology; Dr. Marvin A. Mitchell, instructor in surgery; Dr. John D. Camphell, instructor in psychiatry; Dr. Oliver Arteaga, instructor in clinical ophthalmology; Dr. Chester A. Fort, Jr., from instructor urology; Dr. William N. Ethridge, assistant in urology; Dr. Bomar A. Olds, assistant in otorhinolaryngology, and Dr. Eugene L. Griffin, assistant in obstetrics and gynecology.

Dr. Laura L. Liscomb, Atlanta, announces the opening of offices at suite 222, 478 Peachtree Street, N. E., Atlanta, associated with Dr. Wm. W. Anderson. Practice limited to pediatrics.

Dr. J. Palmer Mayo and Dr. James L. Thompson, Eastman, have purchased the Coleman Memorial Hospital, Eastman, from Dr. Warren A. Coleman. The hospital is on the approved list of the American College of Surgeons, and is a member of the American Hospital Association and the Georgia Hospital Association. While privately owned by Drs. Mayo and Thompson, all reputable physicians will have the privilege of its use for their patients.

Dr. James R. McCord, Atlanta physician and former chairman of the department of obstetrics in the Emory School of Medicine, has resigned from the faculty and has been named professor emeritus. Dr. McCord was awarded on honorary degree of Doctor of Science, in recognition for his many years of faithful service to the highest ideals of the medical profession, at the winter commencement exercises at Emory, March 16.

The Meriwether-Harris Medical Society held its monthly meeting at Georgia Hall, Warm Springs, January 29. Dr. R. L. Bennett, president of Warm Springs Foundation, presided. Dr. Edward Johnson, Manches-ter, gave an interesting discussion on food poisoning.

The Georgia Medical Society held its regular meeting

at 612 Drayton Street, Savannah, March 12. Paper: "Management of Syphilis," Dr. W. J. Brown, Southeastern Rapid Treatment Medical Center, Oatland.

Dr. Howard J. Morrison, Savannah, has returned from active military duty and is re-established at his office, 444 Drayton Street, Savannah. Practice limited to pediatrics.

Dr. Gene Nardin, Atlanta, announces the re-opening of his office, 624-25 Candler Building, Atlanta. Practice limited to internal medicine.

The Newton County Medical Society held its regular monthly meeting at the Alcove, Covington, March 12. Officers for 1946 are: Dr. W. D. Travis, Covington, president; Dr. J. B. Mitchell, Jr., Porterdale, secretary-treasurer; Dr. W. D. Travis, Covington, delegate, and Dr. W. J. Huson, Covington, alternate delegate.

Dr. L. H. Oden, Jr., Blackshear, recently released from the Medical Corps of the U. S. Army, announces the re-opening of his office on Main Street, Blackshear, for the practice of medicine and surgery.

The Richmond County Medical Society entertained 38 members of the society who have been discharged recently from the armed forces of the United States, at dinner at the Sheraton Bon Air Hotel, Augusta, February 19. Dr. Perry Volpitta, president, presided. Dr. G. Lomhard Kelly gave the "Welcome Home" address. Dr. Wm. J. Cranston served as master of ceremonies. Dr. V. P. Sydenstricker told of his war experiences in England and Holland. Dr. John H. Sherman, Dr. Robert Greenblatt, Dr. Kelly, and Dr. David Thomas, were the speakers at the dinner. The honor guests, in addition to those named above, were: Dr. J. H. Sherman, Dr. Richard Weeks, Dr. Philip Mulherin, Dr. Irvine Phinzy, Dr. C. M. Templeton, Dr. Howard McGinty, Dr. Gilbert Klemann, Dr. W. K. Philpot, Dr. W. J. Williams, Dr. Everard Wilcox, Dr. Thos. W. Goodwin, Dr. J. P. Hitchcock, Dr. C. G. Henry, Dr. George Allan Thurmond, Dr. W. A. Fuller, Dr. W. A. Wilkes, Dr. Henry Schmidt, Dr. Bon Durham, Dr. Charles Mulherin, Dr. J. Z. McDaniel, Dr. J. T. Norvell, Dr. Frank Pinson, Dr. George McInnes, Dr. Lidelle Chandler, Dr. John McAfee, Dr. John Morton, Dr. M. H. Wylie, Dr. Charles Westfield, Dr. J. S. New, Dr. Iverson Bryans, Dr. Frank Stelling, Dr. Jack Allgood, Dr. F. N. Harrison, and Dr. Gordon Kelly.

The Cherokee-Pickens Medical Society held its first meeting for the year 1946 at Canton, March 26. The purpose of the meeting was re-organization, election of officers, new members and delegates to the annual session of the Medical Association of Georgia. The following officers were elected: President, Dr. J. T. Pettit, Canton; Vice-President, Dr. E. A. Roper, Jasper; Secretary-Treasurer, Dr. Robt. T. Jones, III, Canton; Delegate, Dr. C. R. Andrews, Jr., Canton; Alternate Delegate, Dr. John R. Lewis, Canton; Board of Censors: Dr. J. C. Roper, Jasper, Dr. A. M. Hendrix, Canton, Dr. I. F. Scofield, Tate, Dr. C. R. Andrews, Jr., Canton, and Dr. T. J. Vansant, Woodstock. New members elected were: Dr. John R. Lewis, Jr., Canton, and Dr. I. F. Scofield, Tate. Dr. R. M. Moore, of Waleska, was elected an honorary member.

Dr. Hayward S. Phillips and Dr. Linus J. Miller, Atlanta, announce their return from military service and are now resuming their former practice of anesthesiology.

Dr. David Henry Poer, Atlanta, announces the re-opening of his office, 1209 Medical Arts Building, 384 Peachtree St., N. E., Atlanta. General surgery.

Dr. Vernon E. Powell, Atlanta, having returned from military service with the Army Medical Corps, announces the resumption of his practice, Roberts' Memorial Clinic, 768 Juniper Street, N. E., Atlanta. Associated with Dr. E. Van Buren, Dr. Byron J. Hoffman and Dr. C. J. Williams. Practice limited to internal medicine.

The Southeastern Surgical Congress met in Memphis, Tenn., March 11-13, 1946, for its first session since 1942. The organization was founded in 1930 by Dr. B. T. Beasley, Atlanta, and has a membership of 650 surgeons from 11 southeastern states. It is the second largest organization of its kind in the United States. Dr. Edgar F. Fincher, Atlanta, assistant professor of surgery in the Emory University School of Medicine and chief of neurosurgical service at Grady and Emory University hospitals, gave an illustrated lecture on "Differential Diagnosis of Intervertebral Cartilage Ruptures and Tumors of the Spinal Cord Within the Lumbar Canal." Officers are as follows: President, Dr. Alton Ochsner, New Orleans; President-Elect, Dr. E. L. Henderson, Louisville, Ky.; Vice-President, Dr. Fred Waas, Jacksonville, and Secretary-Treasurer, Dr. B. T. Beasley, Atlanta.

Dr. C. W. Roberts, Atlanta, represented the Medical Association of Georgia at the first annual meeting of the National Conference on Rural Health held at the Palmer House, Chicago, March 30. Committee on Rural Medical Service, American Medical Association: Dr. F. S. Crockett, chairman, Lafayette, Ind.; Dr. E. J. McCormick, Toledo, O.; Dr. Victor Johnson, Chicago, Ill.; Dr. C. W. Roberts, Atlanta, Ga.; Dr. H. B. Mulholland, Charlottesville, Va.; Dr. J. Paul Jones, Camden, Ala.; Dr. L. W. Larson, Bismarck, N. D.; Dr. Olin West, Chicago, Ill.; and Mr. Thomas A. Hendricks, Chicago, Ill.

Dr. R. M. Reifler, Macon, recently discharged from the armed services after having served almost four years, announces that he is resuming the practice of dermatology, 418-19 First National Bank Building, Macon.

Dr. William G. Hamm, Atlanta, announces his release from active duty in the Medical Corps, U. S. Naval Reserve and his resumption of private practice, 1101 Medical Arts Building, 384 Peachtree Street, N. E., Atlanta. Practice limited to oral and plastic surgery.

Dr. J. R. Shannon Mays, Macon, having completed his service in the Army of the United States, announces the opening of his office for the practice of neuropsychiatry, Doctors Building, 700 Spring Street, Macon.

The Ninth District Medical Society met at Newton and Ward's Undertaker Parlor, Gainesville, March 20. The meeting was called to order by the president, Dr. E. F. Chaffin, Toccoa. Invocation, Rev. Henry Stokes, Jr., pastor First Baptist Church, Gainesville; Welcome Address, Dr. Hartwell Joiner, Gainesville; Response to Welcome Address, Dr. C. L. Ayers, Toccoa; Address, Dr. Cleveland Thompson, Millen, president of the Medical Association of Georgia. "Duplication of Alimentary Tract," Dr. Edward W. Grove, Gainesville; "Case Report of Duplication of Ileum," discussed by Dr. C. D. Whelchel, Gainesville; "Practical Obstetrics," Dr. Richard Torpin, Augusta, chairman and professor of the departments of obstetrics and gynecology, University of Georgia School of Medicine. Dr. Edgar D. Shanks, Atlanta, secretary-treasurer of the Medical Association of Georgia, discussed "National Medical Legislation." The following officers were elected: President, Dr. Edward W. Grove, Gainesville; Vice-President, Dr. H. H. Lancaster, New Holland; and Dr. Pratt Cheek, Gainesville, was re-elected secretary-treasurer.

The Richmond County Medical Society met in the Dugas Auditorium at the University of Georgia School of Medicine, Augusta, March 19. Paper: "Intriguing Cases of Heart Disease and Their Cures," Dr. Paul Dudley White, Boston, Harvard Medical School lecturer and heart specialist.

Dr. Eli A. Rosen, Dalton, recently released from the Medical Corps of the U. S. Army, has resumed his practice of medicine, 215 North Pentz Street, Dalton.

Dr. C. F. Holton, Savannah, chief surgeon, Central of Georgia Railway Hospital Department, announces the promotion of two Macon surgeons. Dr. A. R. Rozar, formerly company surgeon, has been promoted to consulting company surgeon, and Dr. O. F. Keen, formerly assistant company surgeon, was promoted to company surgeon.

Emory University School of Medicine, Atlanta, announces the following faculty members have returned from military service: Dr. Mason Baird, assistant professor in clinical ophthalmology; Dr. Edgar Boling, instructor in surgery; Dr. Taylor S. Burgess, associate in clinical otorhinolaryngology; Dr. F. Phinizy Calhoun, Jr., instructor in clinical ophthalmology and eye pathology; Dr. Chester A. Fort, Jr., associate in urology; Dr. Clarence Dixon Fowler, assistant in pediatrics; Dr. Robert H. Gillespie, assistant in obstetrics and gynecology; Dr. William G. Hamm, associate in surgery (plastic); Dr. George A. Holloway, instructor in obstetrics and gynecology; Dr. Aubrey L. Huskey, instructor in clinical otorhinolaryngology; Dr. A. Park McGinty, assistant in medicine; Dr. Philip H. Nippert, instructor in dermatology; Dr. David Henry Poer, instructor in clinical otorhinolaryngology; Dr. A. Park Smith, Dr. Carter Smith, associate in medicine; Dr. Homer S. Swanson, associate in surgery (neuro). New members of the faculty are: Dr. Donald T. Chamberlin, assistant in medicine; Dr. Hiram Kite, assistant professor in clinical surgery (orthopedics).

Dr. G. E. Seymour, Leesburg, announces the opening of his office for the practice of medicine, Faircloth Drug Store, Leesburg.

Dr. F. A. Sims, Jr., Lawrenceville, recently discharged from the Medical Corps of the U. S. Army, has resumed the practice of medicine at Lawrenceville.

Dr. Richard Lyndon Smith, Cochran, announces his association with his father, Dr. A. L. Smith, Cochran, for the practice of medicine.

Dr. Daniel B. Terry, Homerville, recently released from the Medical Corps of the U. S. Naval Reserve, will resume his association with the Huey Hospital, Homerville, in the practice of medicine.

Dr. Walter G. Thwaite, formerly of Macon, announces his separation from the Medical Corps of the U. S. Army, and the opening of his office in the practice of medicine, Lee Street, Quitman.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, March 26. Paper: "The Use of Thiouracil in Hyperthyroidism," Dr. John L. Elliott.

Dr. L. J. Roberts, Jr., Carrollton, recently discharged from the Medical Corps of the U. S. Army, is associated with Dr. W. E. Thomasson, Carrollton, in the practice of medicine.

Dr. Exum Walker, Atlanta, announces his separation from military service and the resumption of the practice of neurosurgery, 864 Juniper St., N. E., Atlanta.



The Walton County Medical Society held its regular monthly meeting at Hotel Monroe, January 29, 1946. Officers are: President, Dr. Charles S. Floyd, Loganville; Vice-President, Dr. Phillip R. Stewart, Monroe; Secretary-Treasurer, Dr. Lynn M. Huie, Monroe; Delegate, Dr. Charles S. Floyd, Loganville; Alternate Delegate, Dr. Phillip R. Stewart, Monroe.

The Gastrointestinal Clinic of the University of Georgia School of Medicine, Augusta, announces because of incidental expenses, such as x-ray film and materials, added clerical help, etc., it will be necessary to charge two dollars (\$2.00) for a first visit to the gastrointestinal clinic and one dollar (\$1.00) for subsequent visits.

The Crawford W. Long Memorial Hospital, Atlanta, announces the organization of the Out-Patient Clinic, and that ten hospital beds are available for service cases.

The Southeastern Section of the American Urological Association held its tenth annual meeting at the Bon Air Hotel, Augusta, March 21-23, with Dr. William M. Coppridge, president, of Durham, N. C., presiding. The latest scientific advances in the field of urology were covered in addresses by some of the leading specialists in urology. Among the topics covered is the advance in therapeutics, medication and surgery which is said to be more profound in its application to casualties of World War II over any preceding war. The following officers were elected: President, Dr. Hubert K. Turley, Memphis; President-Elect, Dr. Robert B. McIver, Jacksonville; Vice-President, Dr. William M. Coppridge, Durham; Secretary-Treasurer, Dr. Harold P. McDonald, Atlanta. Executive committee: Dr. F. Thomas Boudreau, Alabama; Dr. Russell B. Carson, Florida; Dr. J. C. Keaton, Georgia; Dr. W. R. Miner, Kentucky; Dr. H. T. Beacham, Louisiana; Dr. Orion T. Finklea, South Carolina; Dr. I. G. Duncan, Tennessee. Editorial board: Dr. Montague L. Boyd, Atlanta. The Georgia surgeons who are candidates for membership are: Dr. Donald Beard, Dr. Reese Clinton Coleman, both of Atlanta; Dr. J. Robert Rinker, Augusta; and Dr. S. Elliott Wilson, Savannah.

Dr. J. H. Terrell, Dr. C. L. Ayers and Dr. H. L. White, all of Toccoa, received certificates of merit and the Selective Service Medal for distinguished and meritorious service in connection with the duties performed without recompense for the nation in time of war, in an impressive and dignified service, at a recent meeting of the Toccoa Kiwanis Club. Hon. Frank Gross presented the awards and in a brief speech congratulated the Toccoans for the "untiring and invaluable services they had rendered the people of Stephens County and the United States during World War II."

Dr. Thomas W. Goodwin, Augusta, recently discharged from the U. S. Navy Medical Corps, has resumed his practice of general surgery with offices in the Southern Finance Building, Augusta.

Dr. John McGehee, Cedartown, who was recently released from the Medical Corps of the Army of the United States, has resumed his practice of medicine, 206 Herbert Street, Cedartown.

The Muscogee County Medical Society met recently at the Ralston Hotel, Columbus. Dr. J. M. Wilson, secretary-treasurer of the society, announced that Dr. R. C. Major, Augusta chest surgeon, would discuss "Trends in Chest Surgery."

Dr. W. K. Philpot, Augusta, recently released from the U. S. Navy Medical Corps, has resumed his medical practice with offices in the Doctors Building, Augusta.

Dr. Walter J. Revell, Louisville, recently received his

discharge from the Medical Corps of the U. S. Navy and announces the opening of offices for the practice of medicine in the Polhill Building, Louisville, the same offices used by his father, the late Dr. S. T. R. Revell.

The War Department, Washington, recently lowered the discharge requirements for medical officers to permit the release of 7,000 additional doctors within the next five months. By that time all but approximately 4,000 of the 41,000 physicians who were taken into the Army during the war will be back home. Physicians and dentists, except for some 800 scarce specialists, will be released providing they have 60 points, are 45 years old or have had 39 months of active duty.

"The Doctors Talk it Over" is broadcast coast-to-coast every Tuesday, 9:30-9:45 P. M., presented by Lederle Laboratories, Inc., New York, N. Y. The following distinguished guest speakers will be presented during April: Louis I. Dublin, Ph. D., Vice-President of the Metropolitan Life Insurance Company; Dr. Harry L. Alexander, Department of Internal Medicine, Washington University, St. Louis, Mo.; Dr. W. H. Sebrell, Chief, Division of Physiology, U. S. Public Health Service, Bethesda, Maryland; Brig. General Eugene G. Reinartz, A. A. F. School of Aviation Medicine, Randolph Field, Tex.; and Brig. General William C. Menninger, Office of the Surgeon General, Washington, D. C.

The University of Georgia School of Medicine, Augusta, announces that Dr. F. Deanette Adams, prominent Boston physician, delivered the baccalaureate address when 68 members of the senior class received their degrees as doctors of medicine, in the music hall of the City Auditorium, March 25. Dean G. Lombard Kelly conferred the degrees and administered the Hippocratic oath. Sixty members of the second class to graduate under the accelerated wartime program received reserve commissions in the Army and Navy. Fifty were made first lieutenants in the Army Medical Corps Reserve, presented by Major Roy S. Haggard, commanding officer of the Army Special Training Program Detachment, and ten were made lieutenants (junior grade) in the Naval Medical Corps, given by Lt. Wilburn Tucker, USNR, Atlanta.

The Atlanta Clinical Society announced two lectures at the Academy of Medicine, Atlanta, April 9 and 10, by Dr. Tracy B. Mallory, Boston, pathologist at Massachusetts General Hospital and editor of Cabot case reports for the New England Journal of Medicine. His subjects were: "Some Features of the Pathology of Shock," and "Pathology of Epidemic Hospitals."

Nine members of the faculty of the University of Georgia School of Medicine, Augusta, presented papers at a recent meeting of the Federation of American Societies for Experimental Biology, at Atlantic City, N. J. The group included: Dr. W. F. Hamilton, Dr. Philip Dow, and Dr. John W. Remington, of the department of physiology; Dr. R. A. Woodbury, Dr. Russell A. Huggins, Dr. Raymond P. Ahlquist, and Dr. George Child, department of pharmacology; Dr. W. K. Hall and Dr. Sam Singal, department of biochemistry; and Dr. V. P. Sydenstricker, of the department of medicine.

The Emory University School of Medicine, Atlanta, awarded 64 medical degrees at the winter graduation exercises held in the Glenn Memorial Auditorium, March 16. Dr. Winton Elizabeth Gambrell received the first doctor of medicine degree to be awarded a woman by Emory's medical school in its 85 years of history. Since 1937, Dr. Gambrell had wanted to enter Emory's school of medicine, but it seemed the school was the bailiwick of the male species alone. Finally, in 1943—the first year of the war-accelerated program—Dr. Gambrell's pleas and letters brought results. Tradition was shattered; she became the first woman to enter the medical

school. Two years later more women were admitted, until now there are 12. Dr. Daniel C. Elkin, Atlanta, chairman of the department of surgery at Emory University School of Medicine, and president of the Southern Surgical Association, was the principal speaker at the graduation exercises.

Hon. Ellis Arnall, Governor of Georgia, has appointed to the newly-created State Workmen's Compensation Medical Board the following named physicians: Dr. Hugh Bailey, Atlanta, chairman; Dr. John Funke, Atlanta; Dr. Albert Rayle, Atlanta; Dr. Jack C. Norris, Atlanta; and Dr. Ernest F. Wahl, Thomasville.

The Georgia Section of the American College of Surgeons will have a breakfast at Hotel Dempsey, Macon, May 9, 8:30 A. M. All fellows are invited to attend. Dr. M. T. Harrison, Atlanta, Chairman.

Only residents of Fulton and DeKalb counties are eligible for treatment at Grady Hospital and Steiner Clinic, Atlanta, according to information received from Grady Hospital.

Non-resident patients are being referred to Steiner Clinic by physicians and friends. This causes such patients needless expense, the hardships of trips, and disappointment because the hospital cannot take them in. In all such cases, effort is made to obtain treatment for these patients under the State Cancer Control Program, which, of course, serves only Georgia patients. This entails delay and nearly always the necessity of the patient returning to his home county for authorization of the Department of Public Welfare, in order to meet requirements of the Cancer Control Program. It is needless to state how hard such procedure is for a sick person. If application can be made first by the examining physician to the State Cancer Control Program on the form RCA 1132, supplied by the State Cancer Control Office, the patients will be spared both physically and financially.

Any patient living outside Fulton and DeKalb counties, for whom care at Grady Hospital or Steiner Clinic is wished, will be better served if arrangements are made with the superintendent of the hospital by letter or telephone before the patient is sent in.

#### OBITUARY

*Dr. Clifford Brannen*, aged 56, a practicing physician in Atlanta for 22 years, died March 7, 1946. A native Georgian, Dr. Brannen was a graduate of Emory University School of Medicine, Atlanta, in 1919. For some years he was connected with the staff of Crawford W. Long Memorial Hospital, Atlanta. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the American Medical Association. Surviving are his daughter, Miss Dianne Brannen, Atlanta; his mother, Mrs. Lena Brannen, Statesboro; four sisters, and three brothers. Funeral services were held at Spring Hill, Dr. Robert W. Burns officiating. Burial was in West View Cemetery, Atlanta.

*Dr. McIntosh Marcus Burns*, aged 53, physician and civic leader of Pelham and Mitchell County, died at his residence of a heart attack, March 10, 1946. He was graduated from Emory University School of Medicine, Atlanta, in 1921. Dr. Burns moved to Pelham 14 years ago from Atlanta, where he practiced medicine for 11 years. In Atlanta, he served as president of the Board of Education and was one of the founders of the Good Samaritan Clinic. He was an active member of the Anti-Tuberculosis Association for 10 years. He was a member of the Hand Memorial Methodist Church, Pelham, serving several times as chairman of the board of stewards. He was a member of the Pelham Rotary Club, was a past president of the Mitchell County Medical Society, a member of the Medical Association of Georgia, and the American Medical Association. Survivors are his wife, Mrs. Jewell Tillman Burns, a son,

McIntosh M. Burns, Jr., Pelham, and a brother Edward P. Burns, Chicago. Funeral services were held at the Hand Memorial Methodist Church, Pelham, with Rev. Bernard L. Brown officiating, assisted by the Rev. Dennis Starnes. Burial was in West View Cemetery, Atlanta.

*Dr. Ralph Montgomery Goss*, aged 67, of Athens, one of the state's best known surgeons and physicians, died March 13, 1946. Dr. Goss was born in Madison County, son of the late Dr. and Mrs. Isham Goss. He was graduated from George Washington University School of Medicine, Washington, D. C., in 1906. He was a fellow in the American College of Surgeons and fellow in the American College of Physicians, and at the time of his death was a member of the credentials committee for Georgia for the surgeons' organization. For a number of years he served as attending surgeon at Athens General Hospital and for the University of Georgia, and for a long period of time had been Athens surgeon for the Southern Railway and the Central of Georgia Railroad. Dr. Goss was a deacon and member of the First Presbyterian Church, also a member of the Athens Rotary Club, the Physicians' and Surgeons' Medical Society, former president of the Clarke County Medical Society, former secretary of the Eighth District Medical Society, a member of the Medical Association of Georgia, the American Medical Association, and the Alpha Kappa Kappa national medical fraternity. He was married in 1915 to Miss Callie King Lumpkin, Athens, and from this union was born a son, Ralph M. Goss, Jr. Mrs. Goss died in 1931. In 1933 he married Mrs. Ethel Hodgson, who, with her son, Walter Hodgson, Jr. and Ralph M. Goss, Jr. are the immediate survivors. Funeral services were held at the graveside in Oconee Hill Cemetery, Athens, with Dr. Eugene L. Hill and Dr. Harvey C. Holland officiating.

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

**HEALTH OFFICERS WANTED:** Positions are open in Georgia for county and district commissioners of health. Salaries for experienced public health physicians range from \$4800 to \$6600. Salaries for physicians with public health training who are entering the field range from \$3960 to \$4920. Liberal travel allowances supplement these salaries. Tenure of office is assured by a merit system. License to practice medicine in Georgia is required. Ample opportunities for training are offered with liberal stipend while in training. Write T. F. Abercrombie, M. D., Director, State Health Department, State Office Building, Atlanta 3, Georgia, for application forms and full details.

**TUBERCULOSIS CONTROL OFFICERS WANTED:** A program of increased emphasis on the control of tuberculosis requires nine additional tuberculosis control officers in the Georgia Department of Public Health. Salaries range from \$4800 to \$6600 plus travel expenses, according to education, experience, duties assigned and length of service. Some positions are available for physicians experienced in tuberculosis diagnosis and treatment who do not yet have public health experience. Write T. F. Abercrombie, M. D., Director, State Health Department, State Office Building, Atlanta 3, Georgia, for application forms and full details.



# THE JOURNAL

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### THE DOCTOR IN THIS NEW DAY

CLEVELAND THOMPSON, M. D.  
*Millen*

Fellow members of the Medical Association of Georgia; Ladies and Gentlemen:

This is a happy event! The gathering together again of the doctors of Georgia in sessions for organization work, for study, and for fellowship. It is a great experience to welcome back those men who comprised the medical personnel of the armed forces in whom we feel such pride. Their great service during the war was an amazing achievement which is the envy of the world, and was a source of comfort to those of us who had loved ones on the battle field. I am fully cognizant of the great privilege which is mine to have been the president of such a body, in such a day as this. With humility and gratitude I estimate how greatly you exalted me. I did not suspect that I would be in office two years, and in many ways the program I had planned was defeated by the demands of war. Still they have been years full of fine associations and cooperation, and I feel unbounded pride in them

### *This Is A New Day*

The pages of history have turned rapidly since we last met in May 1944. They have recorded terrible suffering, noble sacrifice, amazing war strategy, scientific development beyond all imagination, and the expenditure of money inconceivable to most of us. The late days of 1945 told the story in big headlines of the close of history's greatest war—the victorious end for us, and for our allies. These last days recorded the beginning of the homeward trek of millions of American soldiers from all corners of the earth, and when a new year dawned a big percentage of them were here

to take up their work again where they had left off when they were called to war. They have come back to a new day—I might almost say a new world. Distance has vanished; daily mail and passenger planes shuttle across the oceans; and all nations are now close neighbors.

Our doctors went to war armed with the sulfa drugs—the most powerful weapon we knew against infection. They came home with penicillin, blood plasma, streptomycin, and the mass treatment of venereal disease with modern agents; and with the new developments in obstetrics, general medicine, surgery, and psychiatry, which make yesterday's methods obsolete. These developments in medicine emphasize more and more the importance of the general practitioner, and demand more and ever more training. Always in medicine something old is passing and something new is being born. Doctors cannot treat sickness as they did two years ago; science has moved too fast for that. Our physicians who were in the armed services have come home to find it difficult to readjust to civilian practice again, and a great many of them are taking "refresher" courses before going back to work. They do not need to renew their knowledge more than those of us who have been buried in a heavy practice for several years. Said an old philosopher, "The most fearful thing in the world is an active ignorance." And nowhere does this apply with such emphasis as in the practice of medicine. If the war taught us anything it is that men of all skills and all professions must have continuous training. Yesterday many doctors carried their patients to the hospitals in larger centers and turned them over to a specialist or a surgeon. In this new day he will treat his patient in a hospital for which he himself is responsible; and training for this is an inevitable necessity.

President's address before the Medical Association of Georgia, Macon, May 9, 1946.

### *Changing Values In These Moving Times*

You and I have lived through the most amazing scientific age in all history. We have been contemporary with Edison, Curie, Orville Wright, Marconi, Bell, Roentgen and Ford. But all that they accomplished—in great comforts, conveniences and aids to science—cannot compare with the demands of this new day when *power* is king—undreamed of power; not the power we were accustomed to last year—money, politics, gadgets, ships, guns and tanks—but manpower, production power, striking power, speed power, chemical power, atomic power, before which thinking man stands awe-stricken and chilled to the marrow. But the new-day power most seriously affecting our profession is *The Power of Public Opinion*. We have never before been seriously concerned about this.

But now our profession is face to face with the opinion of the American people who have been made suspicious of doctors by propagandists. The general public is more intelligent than is generally believed and amply capable of arriving at right conclusions when facts are presented to them. They are entitled to a clear, frank explanation of what the purposes and ideals of organized medicine are and what medicine has done, is doing and intends to do for the public good. Legislators and social-welfare-minded laymen are sensitive to the need of adequate medical and hospital care for all citizens, we grant in magnanimous spirit; they are attempting to meet the situation by setting up a plan of regimentation and bureaucracy, after the pattern of social security and old age pensions. It is an amazing anomaly that a man wanting titles drawn up seeks a lawyer; or expecting to build a house, goes to an architect; yet that same man will listen to politicians concerning the medical welfare of his family and his nation, and allow them to make regulatory laws which they finally are compelled to turn over to the doctor to execute. This reverts to the ingrained ethics of the doctor to keep his mouth shut concerning what he sees and knows professionally, and to ever avoid publicity of any sort. He has not button-holed the man on the street concerning sickness insurance or prepaid hospital

care, nor has he appealed to the editor of a paper to give space to a discussion of it. The concerned layman has! And so we are drawn into a controversy which, for the sake of this same layman and his sick family as well as our own progress and development, we cannot ignore.

It is conceded that there is no disagreement between laymen and our profession on the point that every American citizen, regardless of financial circumstances, should receive adequate medical care, and *adequate* means care of good quality. We have standards of medical practice and hospital care in the United States second to none in the world of today, but we are not the healthiest nation in the world. The reason is that the majority of our people belong to the lower income brackets and cannot avail themselves of these high standards. Medical care costs money. Polls have shown that from 30 to 40 per cent of the American people have put off going to a doctor because of the cost. Certainly no one can have any more hospital and medical care than someone is able and willing to pay for.

Our problem is to be sure that these medical economic and welfare questions are adequately answered in such a manner that the best elements of medical science and medical practice are maintained. It is important that the quality of medical care does not suffer in our effort to increase its availability.

The average doctor is so consumed with the work of his profession that he does not read all of the scientific material that comes to him, much less that relating to the problems of medical economics and the threat to him and to his people of the socialization of medicine. But the change in the situation which we face today has come about so rapidly and so decidedly that we must revise our habits of thinking and planning. The proposals in Britain's Health Act are a distinct shock to us, that her hospitals and medical men be taken over by the government. Britain's men of science have fought long years against these socialistic threats. It is incongruous indeed that a nation bled white by its battle for democracy should stand waiting to make pawns of the members of her most distinguished profession—



men who have maintained a dignity and scientific progress revered by the enlightened world.

I believe that the most urgent responsibility and duty of the Medical Association of Georgia today is the development of an acceptable comprehensive voluntary insurance plan in accord with the principles laid down by the American Medical Association in its National Health Program—a program planned to protect every citizen of the state and of our country against the high cost of sickness, and of hospitalization. Twenty states have already set up this program, and recently our sister states South Carolina and Florida have completed theirs. We cannot disregard the growing interest of the public in a prepayment program. They want scientific medical care, but they also want some provision made by which they can pay for it. Organized medicine has gained enough experience for us to offer now something constructive, and something which should be beneficial. The problem is difficult, but the need is immediate, and the stakes are too high for all concerned to permit of longer delay. Let not those who follow us say that we did “too little too late.”

### *Organized Medicine Is The Answer*

Our safety lies in better organization among ourselves and greater concern for those doctors who belong to no medical society and who know nothing of our organization work. While there are 190,000 licensed physicians in the United States, the public work of medicine is carried on now by about 3,000 of them. With 190,000 doctors informed and disseminating the platform of the American Medical Association—a sound platform in every respect—the opinion of the American people regarding socialistic medicine would change.

The unit, and most important factor, in organized medicine is the county medical society. These organizations that seem so personal, and often so futile, are the blood stream of that vast body of 125,000 doctors who form the membership of the American Medical Association. The county medical society can do much toward education of the public, a real function of organized

medicine. I believe the time has come when at least once a year the county medical meeting should be open to the public and these matters of mutual importance to all of us be discussed freely and without repressions. That is where the layman, face to face with his doctor, in whom he has confidence, can get an unbiased picture of the ideals of the medical profession as a whole. Instead of having his ideal of doctors as benefactors of mankind, charitable and generous, in one pocket of his brain; and the need for government direction of medical attention in another, he can get the vision at close range of the program mapped out by the medical profession for the American people. That some county organizations do not function in this day of change and development is an inestimable loss to the profession and to the public.

It is regrettable that more of us have not seen the American Medical Association in action. The enormous amount of work done each year by the official bodies of that organization is inconceivable. The members of its House of Delegates are consecrated to the preservation of the best policies and ideals of American medicine. They do not take their responsibility lightly nor easily. Its Board of Trustees spends vast time and earnest consideration upon the business of the Association. They are faced with many serious problems which they weigh with devoted care. Any member of the Association may bring his problem to it and be sure of impartial consideration. A National Health Program has been promulgated by the Board of Trustees and the Council on Medical Service, which has condensed and clarified the position of American medicine on the points of maternal and child welfare, medical research, the medical care of the veteran, and the part to be played by the voluntary health agencies.

The Association is our bulwark of safety in these days of change and uncertainty. It publishes the best medical journal in the world, with scientific discussions that are unsurpassed, and it carries information concerning the profession in every port of the globe. We can ill afford to be without it.

*The New Day Cannot Escape The Old*

The physician of today is confronted with a volume of practice unthought of a few years ago. Not only is the population per physician greater, but money is more plentiful and the public is better educated in preventative medicine. The cancer educational program and similar programs send thousands of patients to doctors' offices who had never thought of getting a physical examination. This burden of work makes it very hard to give the best we have to every patient we see, yet the instant we cut short an examination, through weariness or other reasons, we are courting tragedy. It is moreover difficult for the tired and overstrained doctor to be as cordial and painstaking as the public expects, and as he wants to be. He has to find the emotional complications and mental anguish that may be at the root of the patient's physical complaints. He has to know and correlate the many things affecting his patient that are not found in the clinical laboratory nor by the x-ray. He not only has to supply acceptable service to people normally, but he has to deal with little people when they are big, as well as with big people when they are little. These are the things that make such a tremendous demand on his time, his body, and his mind.

But in this new day our profession is more than ever dependent upon the traditions and the ethics of the past. Although "change is the law of life," we know that "If the new has no root in the old, it withers. If the old grows no new leaves it dies." Since life is so complicated in this new day, it is all the more necessary that we live by the "Golden Rule." Long before the Sermon on the Mount, the old philosopher of China said, "Do not unto others as you would not that they do unto you."

A century later Hippocrates taught that the secret of happiness is not in what we get from life but what we put into it. And so let us face this new day with minds and hearts alive to its vast changes, to its opportunities and to its responsibilities; but let us stay safely anchored to the unchanging moral and ethical law. Tradition is life's relay race. In our eagerness to get

ahead in the running we must not fail to carry with us the torch handed us from those of the past. If we do, we are untrue to the heritage which they bequeathed to us, we are untrue to this new day which we serve, and we are untrue to the next generation whose youthful hands are reaching out to carry on into the race our accomplishments and our ideals!

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THE ROENTGENOLOGIC DIAGNOSIS OF  
ABDOMINAL ABSCESES

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H. STEPHEN WEENS, M. D.

*Atlanta*

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Roentgenologic investigation has contributed a great deal to our knowledge of acute and chronic abdominal disorders. Among these conditions abdominal abscesses are of particular interest, since their diagnosis and localization are frequently established more accurately by roentgenologic examination than by other clinical methods.

In the roentgenologic study of acute abdominal disease much emphasis should be placed upon roentgenography and fluoroscopy of the abdomen and chest without the use of contrast media. This examination, which can be performed without loss of time and with a minimum of discomfort to the patient, will frequently yield valuable information. Preparation of the patient with cathartics or enemas, as employed in elective diagnostic procedures, is usually not required. Such preliminary procedures may not only be contraindicated for clinical reasons, but may interfere with the proper examination by distorting a given pathologic pattern of the intestine. Only after completion of this survey examination and correlation of the observed findings with all clinical data, should other diagnostic studies such a barium enema or pyelogram be resorted to.

For the mere purpose of description abdominal abscesses may be divided into five groups:



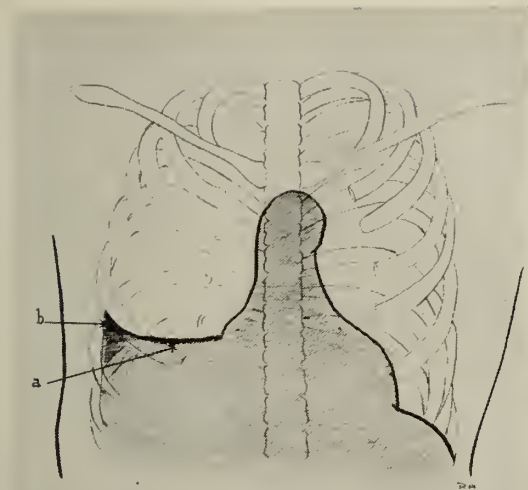


Figure 1

Right subphrenic abscess. Note elevation and irregularity of right diaphragm (a); small pleural effusion (b).

1. Subphrenic abscesses.
2. Intraperitoneal abscesses.
3. Retroperitoneal abscesses.
4. Abdominal wall abscesses.
5. Abscesses of intra- and retroperitoneal organs.

This subdivision is entirely arbitrary. It is realized that it is not only incomplete but that many abscesses may be classified in more than one category.

### *Subphrenic Abscesses*

Subphrenic abscesses, on account of their location, are particularly amenable to recognition by roentgenologic examination<sup>2,6</sup>. The diaphragm of the corresponding side is usually elevated, slightly irregular and will reveal markedly decreased or absent motility (Fig. 1a). Attention should be paid to the early appearance of a small amount of pleural fluid in the costophrenic angle of the involved side (Fig. 1b). On occasions the pleural effusion observed in subphrenic abscesses may be more pronounced and empyema and lung abscesses may follow an associated diaphragmatic fistula. The examiner should be aware that diminished diaphragmatic motility *per se* is not a pathognomonic sign of subphrenic abscesses, but may be encountered in other intra-abdominal, pulmonary, and pleural conditions. Dis-

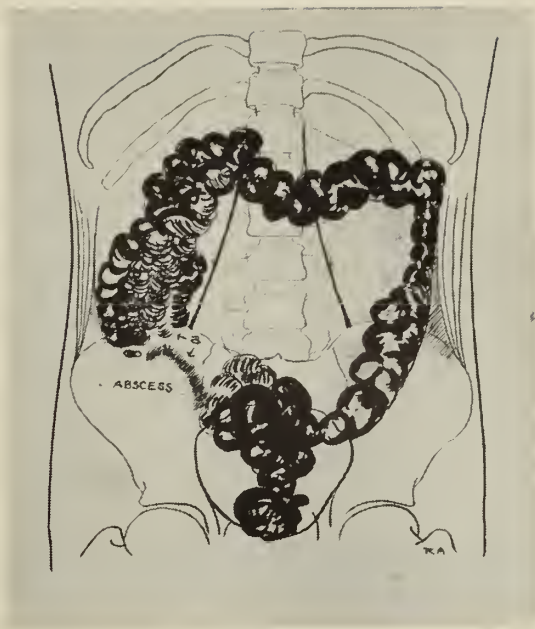


Figure 2

Survey film of abdomen. Appendiceal abscess. Note displacement of gas shadows of cecum and terminal ileum (a).

placement of the organs adjacent to the subphrenic abscess, such as liver, spleen, stomach, and colon, may be a helpful sign in the differential diagnosis. Not infrequently gas is observed in the area of the subphrenic abscess indicating the presence of a gas-forming organism or fistula between the abscess and a hollow viscus, or the bronchial tree. Subphrenic abscesses may be entirely retroperitoneal, in which case elevation of the posterior portion of the diaphragm is more pronounced. This is frequently observed in retroperitoneal subphrenic infections of renal origin.

### *Intraperitoneal Abscesses*

The roentgenologic features of intraperitoneal abscesses are less commonly known than those of subphrenic abscesses. Localized intra-abdominal abscesses may be visualized on survey film studies of the abdomen as a space-occupying process displacing the intestine, which is usually distended in the region of such an infection. This is frequently clearly demonstrated in appendiceal and pelvic abscesses<sup>1</sup> (Fig. 2). The intestinal distention is believed to be the re-

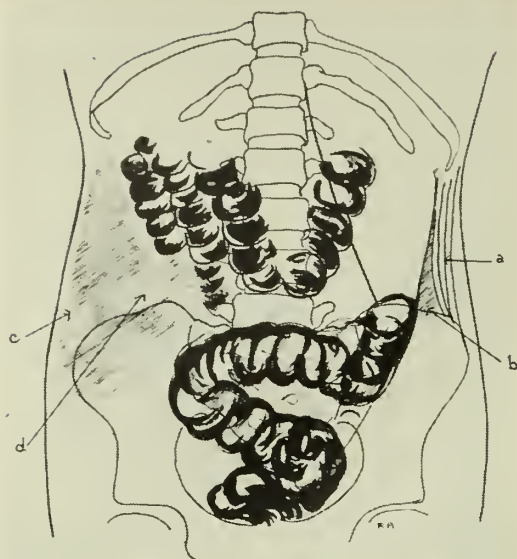


Figure 3

Survey film of abdomen. Appendiceal abscess with retroperitoneal extension. Normal left abdominal wall. Clear outline of muscle layers (a) and subperitoneal fat layer (b). Marked edema of right abdominal wall and subperitoneal fat layer (c). Obliteration of psoas shadow and abscess displacing intestinal shadows (d).

sult of ileus or mechanical obstruction. On survey films it may be difficult to differentiate between well encapsulated abscesses and tumors, such as intra-abdominal cysts or large bowel neoplasms, necessitating examination with contrast media. Even then the tumor-like appearance of appendiceal abscesses may be quite striking.

Of particular importance is the roentgenologic study of the abdominal wall adjacent to the abscess. In film studies of satisfactory diagnostic quality the intermuscular and subperitoneal fat layers of the abdominal wall may be recognized as well demarcated lines of decreased density (Figs. 3a and 3b). In abscesses which are adjacent to the parietal peritoneum considerable edema of the subperitoneal intermuscular fat layer may develop, causing their obliteration on roentgenologic examination<sup>4,5</sup>. The observation of gas formation due to gas forming organisms may in occasional cases be of considerable aid in the differential diagnosis between tumor and abscess<sup>10</sup>. Care must be taken to differentiate this from perforation of a carcinoma, or ulcer, with resulting fistula formation.

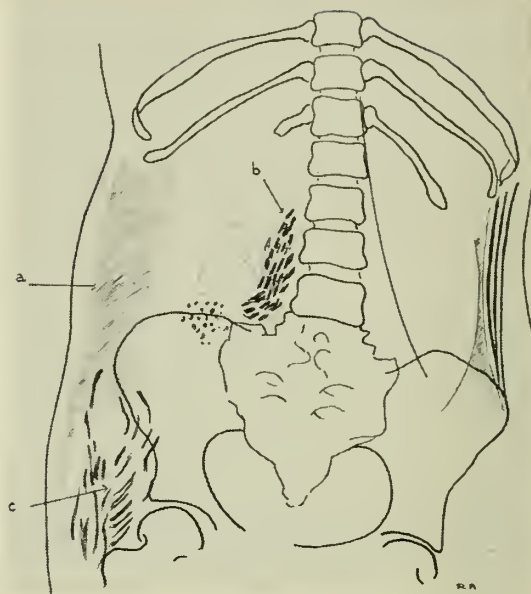


Figure 4

Survey film of abdomen. Gas formation in retroperitoneal abscess. Edema of abdominal wall structures (a). Gas formation in psoas muscle (b) and in soft tissues of thigh (c). Right psoas shadow obliterated.

### *Retroperitoneal Infections*

Retroperitoneal abscesses, regardless of their origin, may lead to distortion or obliteration of the psoas shadow on the corresponding side. The obliteration of the psoas shadow may be incomplete, depending a great deal upon the location and extent of the abscess. Extension of the infectious process into the flanks frequently produces edema of the fat layers of the abdominal wall which may become widened and indistinct on roentgenologic examination (Figs. 3c and 4a). Gas formation in these processes may be more common than is generally appreciated and can be recognized on roentgenologic examination (Fig. 4b). The gas formation is by no means a pathognomonic feature of *Cl. welchii* and related organisms, but may be observed in infections due to colon bacilli and anaerobic streptococci. This seems to be more frequent in diabetic patients, since the high dextrose level of the tissue fluids favors growth and gas formation of *E. coli* and related organisms<sup>3</sup>. The infection and gas formation may spread from the retroperitoneal space into the soft tissues of the thigh



where the process may become more conspicuous than at the site of origin (Fig. 4c). With the aid of pyelograms and barium enemas these abscesses may be better localized and eventually their origin from spine, kidneys or colon can be determined.

### *Abdominal Wall Abscesses*

The roentgenologic examination is a valuable aid in locating and determining the relationship of an abdominal wall abscess to the various layers of the abdominal wall. Of particular clinical importance is the differential diagnosis between gas formation in these abscesses and herniated intestinal loops which are characterized by their typical pattern and segmentation.

### *Abscesses Within Intraperitoneal and Retroperitoneal Organs*

The recognition of abscesses of intraperitoneal and retroperitoneal organs depends to a great extent upon their size, location and the organ involved, and upon the roentgenologic procedures employed. Thus, smaller liver abscesses may not reveal any significant roentgenologic changes, whereas kidney abscesses of comparable size may show definite signs on pyelographic studies. Frequently the appearance of the abscess is largely determined by the extension into the surrounding structures. A splenic abscess, for instance, may manifest itself as a localized subphrenic abscess. Abscesses and phlegmons localized in the wall of hollow viscera may occasionally be recognized on roentgenologic examination by the presence of bacterial gas formation, a process designated as emphysematous infection. Thus emphysematous infections have been described in connection with inflammations of the gallbladder<sup>9</sup>, urinary bladder<sup>8</sup>, uterus<sup>7</sup> and stomach<sup>11</sup>.

### *Summary and Conclusions*

Roentgenologic examination of the abdomen is a valuable procedure in the recognition of intraperitoneal and retroperitoneal abscesses. On roentgenologic studies at-

tention is paid to the motility and position of the diaphragms, the distribution and displacement of intestinal gas shadows, the structure of the abdominal wall and the occurrence of bacterial gas formation. These signs are frequently apparent on roentgenologic and roentgenographic survey examination of the abdomen without the aid of contrast media.

No interpretation of the roentgenologic findings should be done without full knowledge of the clinical findings. It is not claimed that all abdominal intra- and extra-peritoneal infections can be recognized by roentgenologic methods, but in a significant number of cases roentgenologic examination will contribute considerably to early diagnosis and proper localization of abdominal abscesses. Roentgenologic examination should be more frequently employed in the diagnosis of acute abdominal conditions.

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### SQUIBB RELEASES SULFADIAZINE-ASPIRIN CHEWING WAFERS

For the local treatment of infections of the mouth and throat, such as acute tonsillitis and pharyngitis, caused by organisms sensitive to sulfadiazine, Squibb has released a new product known as Diazprin wafers. These are chewing wafers containing 5 grains of sulfadiazine and 3 grains of aspirin incorporated in a wintergreen-flavored paraffin base.

The advantages claimed for Diazprin wafers are: (1) Rapid production of a high salivary concentration of sulfadiazine providing effective medication for inflamed tissues of the throat and (2) the analgesic effect of aspirin on painful mucosa. It is recommended that 1 to 3 wafers be used daily, each wafer being chewed from 1 to 3 hours.

Diazprin wafers are supplied in boxes of 12, each wafer scored and sealed individually in sanitape.

**THE JOURNAL**

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

May, 1946

**MACON SESSION, 1946**

The Ninety-Sixth Annual Session of the Medical Association of Georgia—better known as the Macon session of 1946—showed again that the physicians of Georgia are interested in organized medicine. Not only are they interested in the scientific, the social and the business programs, but they are interested in all phases of human endeavor and in the betterment of human beings to meet the problems of life.

Six hundred and five members of the Association registered for the annual session, the first to be held in two years. This number was augmented by the presence of 91 exhibitors and visitors, making a total of 696 persons registered for the session. One hundred and twenty-seven physicians' wives registered for the Woman's Auxiliary meeting.

The House of Delegates held three meetings, spending considerable time discussing the reports of the various committees. The Council held three meetings and discussed particularly the financial problems of the Association.

A synopsis of the proceedings of this session will be published in *THE JOURNAL* as soon as the reporter has the time to transcribe her notes. Highlights of the session, however, were: 1. Upon the recommendations of the President, the President-elect and the Committee on Public Policy and Legislation, the members in general session voted to sponsor and make an effort to develop, on a state level, some plan of prepayment health insurance; 2. Continue the fight to prevent the regimentation of the medical profession; 3. Continue

through the Association's numerous committees all the activities now in the process of development, including the improvement of health education and public health programs; and 4, the election to honorary membership in the Association of a distinguished layman—Mr. Robert F. Maddox of Atlanta—whose long and faithful years of service as a member of the State Board of Health has endeared him in the hearts of all Georgians.

At the closing session officers were elected. Dr. Ralph H. Chaney, of Augusta, was elevated to the presidency; Dr. Steve P. Kenyon, of Dawson, was elected president-elect; Dr. A. M. Phillips, of Macon, was chosen first vice-president; Dr. C. Purcell Roberts, of Atlanta, was elected second vice-president; Dr. John W. Simmons, of Brunswick, was continued as the parliamentarian; Dr. Edgar D. Shanks, of Atlanta, was re-elected secretary-treasurer; Dr. B. H. Minchew, of Waycross, Dr. Olin H. Weaver, of Macon, and Dr. Allen H. Bunce, of Atlanta, were elected delegates to the American Medical Association, their alternates being Dr. W. R. Dancy, of Savannah, Dr. C. K. Sharp, of Arlington, and Dr. H. C. Sauls, of Atlanta. Others elected were: Dr. W. F. Reavis, of Waycross, chairman of Council; Dr. Marion C. Pruitt, of Atlanta, clerk of Council, and Dr. W. G. Elliott, of Cuthbert, member of Council from the Third District. All members of the present State Board of Health, whose nominations had been confirmed by the Governor of Georgia since the Savannah meeting of the Association in 1944, were duly nominated as provided for in the by-laws of the Association.

Augusta was selected as the meeting place for 1947.

Before final adjournment of the 1946 session resolutions were endorsed thanking the members of the Bibb County Medical Society and the people of Macon for their



gracious hospitality and cooperation in making the Ninety-Sixth Annual Session of the Association one of its best meetings.

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GEORGIA STATE COMMITTEE OFFICE FOR  
THE PROCUREMENT AND ASSIGNMENT  
OF PHYSICIANS CLOSES

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The office of Procurement and Assignment Service for Physicians for Georgia closed May 1, 1946.

For several months the chief function of this office has been to try to secure the release of physicians now in the services so they might return to critical areas within our State. Even though the doctors have been released in large numbers many of them do not wish to return to their former locations on account of no hospital, or inadequate hospital facilities, in their town or county. Other physicians released from military duty wish to take advantage of refresher courses under the G. I. Bill of Rights, or take up some specialty which takes months or years to acquire. With time taking her toll of the older physicians throughout the State, many towns and counties are now in greater distress for want of doctors than during the war. We have had many requests for young doctors now in the service, who have expressed a willingness and a desire to return to these localities should they be released from military duty now that the war is over. That, at first thought, seems simple enough and our committee has recommended the release of many of these doctors. However, when the record of these doctors is reviewed by the Central Committee of Procurement and Assignment in Washington, it is found that most of them have participated in the A. S. T. program to secure their medical education and naturally the Surgeons General of the Army and Navy expect these men to serve a time in the Army or Navy to compensate for these educational advantages.

In other words, at the time they accepted this service in the medical colleges they became "essential," whereas had they not accepted they became "available" for military duty at once.

It should be borne in mind that our committee actions were advisory, with no power to act. Our recommendations were to a Central Committee, Procurement and Assignment Service, Washington, which also was an advisory committee. The Central Committee made recommendations to the Surgeons General of the Army, Navy and Public Health Service. They had the authority and exercised it.

It is with a feeling of pride that our recommendations were, almost without exception, concurred in by the Appeal Committee of the Fourth Service Command, and by the Central Committee in Washington.

We wish to congratulate the doctors of Georgia on their patriotism, for it was much easier to "procure" than it was to "assign."

To the doctors who remained to care for our home folks, we wish to say that we have never seen such devotion to duty. Retired doctors, and those burdened with age and infirmities, have worked night and day to relieve the sick.

To all, let us thank God that the war is over, and let us hope for a lasting peace.

W. A. SELMAN, M. D.  
*Chairman*

EDGAR D. SHANKS, M. D.

JOHN B. FITTS, M. D.

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The American Medical Association will convene in San Francisco July 1, 1946. Its House of Delegates will assemble at 10 A.M., July 1. The scientific programs begin July 3.

All members of the Medical Association of Georgia are invited to attend this session.

Travel and hotel accommodations should be planned in advance of the meeting.

## GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

## OUR NEW ATTACK ON TUBERCULOSIS

Under the greatest difficulties, such as inadequate hospital facilities, insufficient funds for relief for needy patients and their families, and understaffed health and welfare departments, there has been a gradual decrease in tuberculosis mortality in this State. So much has this reduction in death amounted that many have thought that tuberculosis is really "on the run." In a manner of speaking it is, but unless something is done to accelerate the present rate of reduction it will be many a year before we can with truth declare that tuberculosis is no longer a menace to mankind. Tuberculosis has killed more people all over the world than have been slaughtered in all of the wars that have ever been fought. In the United States, during the war just concluded, the deaths from this still great plague almost equaled the number of our forces killed in action. The armed conflict mortality has ceased. It was brought to an end by great effort and expenditure of billions of dollars. The killing by tuberculosis goes on and on. The scourge is worse than war. The thoughtful person wonders why we will not exert ourselves in a concerted effort requiring much less than the enormous amount employed in prosecuting the war to rid ourselves of a foe more deadly, more continuingly deadly than is war.

The methods by which it might be done have been known almost ever since Koch's discovery of the tubercle bacillus. Publicity concerning these methods and the means by which they could be put into effect has been wide and often repeated. Quite a large amount of money was shown to be necessary for effective control but it was never possible to have it made available. Short-sightedness of those who held the purse strings has always made the goal of complete control impossible of attainment. Now, however, hope has arisen anew that victory against this ancient foe may be approaching much more rapidly than was until recently thought possible.

The incentive for a stronger and more determined effort at rapid eradication of tuberculosis came about through the startling results of mass chest x-ray examinations of the supposedly healthy individuals presenting themselves for induction into the military forces. About one per cent—one hundred thousand—had to be rejected because of tuberculosis. The United States Public Health Service, through its new Division of Tuberculosis, conducted similar very large surveys in industry, particularly government operated plants, with about the same results. Comparable results were obtained by the Georgia Department of Public Health in its surveys in industry. Enough sampling of like

character has been done all over the nation to prove that an immense amount of undiscovered tuberculosis is present in the general population. Much of the tuberculosis found in this manner is in the early stage and, therefore, a larger number of more easily curable cases of tuberculosis is located by this means. The type of x-ray, photofluorography by means of 35 mm., 70 mm., and 4 x 5 films, renders the process of case-finding much cheaper than was possible by conventional x-ray. It brings nearer to realization the goal of a chest x-ray for everyone.

*Expansion of Treatment Services*

As this is written it seems certain that Battey General Hospital at Rome will be transferred to the State for use as a tuberculosis sanatorium. It is capable of housing 3,000 patients, three times the present number. It will lend itself to the care of all types of patients, to most modern treatment methods, and makes a complete rehabilitation program possible. In the past, in order that our meager facilities could be most effectively used, we limited admission to the State Tuberculosis Sanatorium to those who could be expected to gain the greatest benefit from special kinds of treatment, particularly lung collapse measures. This policy was extremely valuable, because it made it possible for a great many patients to go on to recovery and prevented future great spread of disease from them. It kept them, in fact, from in turn becoming additional sources of infection, or if they were already communicable cases, made them eventually non-communicable ones. Of course, it was argued that we made a mistake by not hospitalizing the infectious person in whose case no collapse measures were indicated. The contention here being that these cases were spreading infection by remaining at home, thereby nullifying the good brought about by admitting patients for treatment only. This was partly true, no doubt, but it was never intended to neglect those who could not be admitted to the sanatorium. It was felt that the local community in which such a person lived would have to accept the responsibility, through the local health department, local welfare department, other local agencies, and through the cooperation of the patient and his relatives and friends, for his care and treatment, symptomatic and rest, and for proper preventive measures to protect the other members of his family and associates. That the plan was practical and effective is proven by the fact that Georgia with woefully inadequate sanatorium facilities, but with a very active health department, was able to cut its tuberculosis death rate squarely in two in fifteen years, and to keep it below the average of the



United States as a whole in spite of the fact that we were in competition with states having a much greater ratio of sanatorium beds per annual death than we have.

All of us have been quite certain that our progress could and would have been much faster had we been able to hospitalize all who needed it, whether for special treatment or for domiciliary care or isolation. Now, having all of these additional beds, we shall be able to obtain more rapid mastery over this disease because whenever it is desired to have a tuberculosis patient hospitalized it can be done without delay, at least until the time is reached when the institution becomes completely filled.

The State has a quarantine law which permits through court action the forcible detention of recalcitrant patients—those who will not cooperate with the health authorities in observing the precautions necessary to prevent spread of infection. It is hoped that it will not be necessary to invoke action under this law, but this hospital is equipped with detention wards and patients of this class could be properly cared for in it if they refuse to follow instructions of the physician or the health officer, or to accept treatment or care voluntarily.

#### *Expansion of Case-Finding Service*

The fact that hospitalization of tuberculosis cases in all categories is to be easier in the future encourages our greater effort to discover all of the cases there may be. As shown above, we know that x-ray examinations of the masses reveal many previously unknown and unsuspected cases of tuberculosis. It is logical, therefore, that we strive to x-ray everybody, particularly all adults, as quickly as possible. Programs should be adopted everywhere aiming at the x-ray of the entire population in a period not to exceed five years. *It should be remembered that no population group knows exactly what its tuberculosis problem is until each person in it is x-rayed.* It is the purpose of the State Health Department to urge and try to make possible such an achievement. It plans to establish a number of State Health Districts—probably nine—and to assign to each one of these districts a tuberculosis consultant, or control officer. It will be his function to establish, in every way possible, adequate tuberculosis control measures. He will conduct mass photofluorographic chest x-ray surveys, establish local clinics with the aid of local health departments and local physicians. These clinics will afford the means for periodic x-ray examinations of contacts, study of those suspected of having tuberculosis and periodic examination of arrested cases, and for artificial pneumothorax refills in ambulant cases requiring such treatment. He will determine by various means who are the sources of infection and, having found them, see that the necessary steps are taken to prevent spread of infection by them. He can assist in promoting rehabilitation of patients and their families.

In each of these districts the tuberculosis control officer will find that much of the “spade work” has been done. The majority of counties have health departments in which State mobile x-ray service has been available for years. Approximately 40 counties have x-ray apparatus, most of which has been furnished by the State Health Department. The State Health Department will soon have eight 70 mm. photofluorographic x-ray machines for mass surveys and mass x-ray service. The people generally want x-ray service. In a recent mass chest x-ray survey at Savannah, carried on jointly by the State and Chatham-Savannah Health Departments and the United States Public Health Service, about 80 per cent of the adult population—68,000—were x-rayed. A similar service is to be rendered in Columbus, beginning in May. Other cities desire this service and expect it to follow the Columbus demonstration.

The stage is set. Money is being made available. Equipment and personnel are being obtained. A large number of hospital beds is being provided. The fault is ours if tuberculosis is not made a minor problem within ten years.

H. C. SCHENCK, M. D., Director  
Division of Tuberculosis Control  
Georgia Department of Public Health.

#### HEALTHGRAMS

The first wealth is health. Sickness is poor-spirited, and cannot serve anyone; it must husband its resources to live. But health answers its own ends, and has to spare; runs over, and inundates the neighborhoods and crooks of other men's necessities.—*Ralph Waldo Emerson.*

Whatever success has been thus far achieved in controlling tuberculosis is a direct contribution of organized medicine to the welfare of the human race. Critical and querulous comment is rather too commonly heard, charging the medical profession with dereliction of its duty in not suspecting and therefore discovering tuberculosis in its earliest or minimal stage. This criticism is largely unfair, since it is only through the x-ray that the disease can be discovered this early. Although the x-ray has been in use for a good many years, facilities for its adequate application have only recently been generally distributed. From now on it will take the place it deserves as our outstanding diagnostic medium and be used without limitation by internists everywhere.—*Kendall Emerson, M. D., Hoosier Health Herald, February, 1946.*

In tuberculosis the first and greatest need is education; education of the people and through them education of the state.—*Edward Livingston Trudeau.*

#### THE SCHOOL-CHILD'S BREAKFAST

Many a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a “continental” breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, small wonder that he is listless, nervous, or stupid at school. A happy solution to the problem is Pabulum. Pabulum furnishes protective factors especially needed by the school-child—especially calcium, iron and the vitamin B complex. The ease with which Pabulum (or Pabena) can be prepared enlists the mother's cooperation in serving a nutritious breakfast. This palatable cereal requires no further cooking and can be prepared simply by adding milk or water of any desired temperature.

## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1008 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, Walnut 8911; residence, Jackson 7979.

### SUMMARY REPORT OF FIELD WORK IN GEORGIA

LUCY D. GERMAIN, R. N.

*Field Representative,*

*The American Journal of Nursing*

The field representative spent the month of November 1945 in Georgia. During this time she reached approximately 1500 nurses, including 500 students through group meetings numbering in all 44. This by no means includes the many opportunities to talk with nurses and others interested in nursing, or contacts made through visits to Army installations, governmental hospitals and health facilities as well as well known institutions, as the Martha Berry School or the Warm Springs Foundation, or through the radio and the press. It was a new feature to have such an extensive program of publicity both prior to and running concurrently with the period of field work in the State.

The excellent planning began in the office of the Georgia State Nurses' Association, carried through to the districts. Attending the one-day meeting of the association (November 5), at the beginning of the period in the State, afforded an unusual opportunity to become familiar with the nursing program and to meet the nurses. Having the privilege to be in and out of the State office frequently, and at will, was most helpful. Among other things it brought to the attention of the field representative how this is the dynamo for professional nursing in the State and is on a continuous alert.

A meeting of the State Journal Committee and representatives of District 5 (Atlanta) was held before the field representative went out into the states. Through some misunderstanding or lack of correct information, Miss Agnes McGinley, Athens, Georgia, State Journal chairman did not receive any material or communications from the journal office. Those present liked the idea of the function of the committee being educational to contribute toward a better informed membership. Discussions centered around accomplishing this and the best means for everyone to cooperate, including the journal office. Certain patterns were decided upon. These were set

aside, however, at least temporarily, until the new journal chairman, Miss Myrtis Young, of Augusta, became familiar with the program.

Later the field representative had a conference with her. Miss Young plans to contact local chairmen regularly and if possible keep them informed as to the availability of new journal material.

Securing subscriptions has been the chief function of the committee, but in the future more thought and effort will go into *how The Journal* can be used. "How do you use" *The Journal* will supplant to some extent at least "Do you subscribe?"

The degree of interest in *The Journal* varied in different localities. There is much activity in Milledgeville and noteworthy interest in Albany. Of the schools of nursing reporting data to the field representative, Grady School of Nursing in Atlanta has bound volumes back to 1904 and 1905. Except in isolated instances, as for example in Savannah, few students are subscribers. It is commendable though that *The Journal* is included among the periodicals in the Red Cross Recreation Center for veteran nurses in Atlanta. Schools of nursing use *The Journal* in varying degrees of effectiveness and much more emphasis can be placed on its usefulness to graduate nurses. It was here that the field representative spent a major portion of her time—interpreting the use of *The Journal* in terms of what nurses wanted to know, what they were doing, and the programs contemplated in the future.

Nurses in Georgia are vitally interested in improving not only their own welfare but in meeting the demand for increased nursing service. Among the many programs which gave ample opportunity to interpret the use of *The Journal* were: (1) Counseling and Placement; (2) Ways and Means to Meet Nursing Needs; (3) the Curriculum Committee of the Georgia League of Nursing Education; (4) Continuation of the State Nursing Council As a Committee of the Georgia State Nurses' Association; (5) The Very Active Committee on Nursing Arts of the G. L. N. E., and (6) many others.

In addition there is more interest in the practical nurse and her place in the field of nursing.



An industrial nursing association has been organized. Many nurses are engaged in private duty nursing. A number of veteran nurses were already employed in civilian hospitals and taking part in activities of the professional nursing organizations. Many schools are improving library facilities. Here, too, were unlimited opportunities to encourage nurses to use *The Journal*.

Nurses asked many questions. Some led to further discussion on the use of *The Journal* content while others pointed up the need for information: "How can programs be improved?" "How can membership be increased?" "Should meetings be held more frequently?" "What is being done to improve personnel practices?" "Improving public relations?" Counseling and Placement?" Everywhere nurses welcomed the suggestions given. They proudly told about taking part in community health programs, in participating in the proposed hospital and public health program, representing nursing on a local lay organization, and taking part in other public relations activities.

At a subscription dinner given in her honor just before leaving the State, the field representative pointed out how the Georgia State Nurses' Association is going forward in the *Comprehensive Program for Nation-wide Action in the Field of Nursing* as learned from observation of nursing in Georgia. Although the picture is by no means complete, many programs and activities are under way which will contribute a great deal to nursing both within the State and nationally. Among these are:

#### *Nursing Service*

1. Personnel practices are being improved, so far as individual projects within the institution.
2. Group nursing is carried out to some extent.
3. Practical nurses are increasing in number and professional nurses are trying to think through the next best step.
4. Private duty nurses are endeavoring to promote the eight-hour day.

#### *Nursing Education*

1. Two University schools of nursing are being rapidly developed.
2. The plan for centralized teaching for three schools of nursing in Atlanta is being continued.
3. Activities are going forward to improve the content of the curriculum and facilities for teaching in schools of nursing, e. g., libraries, nursing arts and the organization and administration of the curriculum.

#### *Channels and Means of Distribution of Nursing Service*

1. The counseling and placement program.
2. Registries.

#### *Implementation of Standards*

1. Consideration of licensure of all those who

nurse for hire. The Legislative and Auxiliary Workers' Committee is working with the Georgia Citizens' Council.

#### *Public Relations and Information*

1. There is a State Bulletin, and at least one district (5) has its own publication. The Association is responsible for one page in each issue of *The Journal of the Medical Association of Georgia*.

2. Nursing is represented in local and state non-nursing groups; e. g., Advisory Council to the State Board of Health, League of Women Voters (Atlanta), and Women's Advisory Committee to the Mayor (Savannah).

3. Continuous activity in the office of the State Nurses' Association to keep nursing before the public through the radio, press, and other mediums available.

The success of these or any other programs depends primarily on the interest, cooperation and understanding of every nurse. It is here *The Journal* can play an important part, if nurses recognize its usefulness to them in keeping well informed.

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#### NEWS ITEMS

Dr. Charles R. Smith, formerly of Dawson, announces the opening of his offices, 1236 Broadway, Columbus.

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the dining room, April 11. Program: Case No. 1. "Acute Pancreatitis," Dr. C. W. Roberts, Atlanta; Case No. 2. "Hemarthrosis in a Twenty Year Old Male, Diagnosis Undetermined," Dr. Lamont Henry, Atlanta.

Dr. W. R. Baker, formerly of Atlanta and Arden, N. C., recently released after more than three years' service in the U. S. Army Medical Corps, has become a member of the staff of the Taylor Memorial Hospital, Hawkinsville. He will have offices at the hospital where he will limit his practice to surgery.

Dr. Stephen T. Barnett, Jr., Atlanta, announces the re-opening of his offices at 26 Linden Avenue, Atlanta; practice limited to obstetrics and gynecology. Hours by appointment only.

The Bibb County Medical Society held its monthly meeting at Ridley Hall, Macon, April 2. Dr. J. L. Gallimore was in charge of the program.

Dr. W. L. Champion and Dr. Major F. Fowler, Atlanta, announce the association with them of Dr. Reese C. Coleman, Jr., in the practice of urology, Doctors Building, Atlanta.

Dr. T. H. Chesnutt, Colquitt County commissioner of health for more than 17 years, has resigned to enter the practice of medicine at Moultrie.

Dr. L. C. Cheves, Jr., Montezuma, recently discharged from the Medical Corps of the U. S. Army in the Pacific area for almost two years, has re-opened his office for the practice of medicine, Montezuma.

Dr. G. C. Cox, Milledgeville, of the Milledgeville State Hospital medical staff, spent the month of March in Washington, D. C., taking a post-graduate course at George Washington University and observing work at St. Elizabeth Hospital.

Dr. Richard Binion, Milledgeville, was recently appointed by Governor Ellis Arnall as a member of the newly-created advisory board to draw up standards for hospitals in the state.

Dr. William E. Brown, formerly of Greensboro, recently discharged from the Army Air Corps as flight surgeon, announces the opening of his offices at Dawson.

### POST-GRADUATE COURSE IN VENEREAL DISEASE

An intensive post-graduate course in venereal disease will be conducted by the Emory University School of Medicine in cooperation with the Georgia Department of Public Health. It will be held June 27 and 28 at the Grady Memorial Hospital, Atlanta.

This course is planned specifically for the public health physician and the general practitioner. It will be a practical and comprehensive study of the latest methods of diagnosis and treatment of venereal diseases.

The course will be organized almost entirely around clinical material. A few supplementary didactic lectures will be given. Special emphasis will be placed upon the problems of diagnosis and of penicillin therapy.

#### *Tentative Program*

#### I. Diagnosis of Syphilis:

- A. Fundamentals and interpretation of serologic tests; detection of false positive tests, and handling of Wassermann-fast reactions.
- B. Use and technic of darkfield examinations, and differentiation of spirochetes.
- C. Differentiation of genital lesions and skin rashes.
- D. Diagnosis of neurosyphilis; technic of spinal puncture and interpretation of spinal fluid findings.
- E. Clinics on cardiovascular, ocular and neurosyphilitic manifestations; problems in congenital and prenatal syphilis.

#### II. Treatment of Syphilis:

- A. Fundamentals of penicillin therapy and chemotherapy.
- B. Present-day schedules for use in various stages of the disease.
- C. Indications for and technic of fever therapy.

#### III. Diagnosis and Management of Gonorrhea in Adults and Children:

- A. Evaluation of laboratory tests; criteria for cure; treatment of vulvo-vaginitis and ophthalmia.

#### IV. Recognition and Treatment of Chancroid, Granuloma Inguinale and Lymphogranuloma Venereum.

- A. Interpretation and comparative value of biopsies, cultures, smears and skin tests.

Tuition fee for practicing physicians will be \$10.00.

Please fill out registration slip below and mail at once, if interested in taking the course.

To: Dr. Albert Heyman,  
Grady Memorial Hospital,  
Atlanta 3, Georgia

I wish to register for the post-graduate course in venereal disease.

Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Please check:

- ☐ I am a public health physician.  
☐ I am a practicing physician.

#### NEWS ITEMS

Dr. Drew Ferguson, Shawmut, recently released from the Medical Corps of the U. S. Army after having served with the Emory Unit of General Hospital No. 43, as a member of the surgical service, announces the re-opening of offices at Shawmut.

Dr. Norton Frierson, Atlanta, having returned from military service with the U. S. Army Medical Corps after having served almost four years, announces his association with Dr. Leo P. Daly, Medical Arts Building, Atlanta.

Dr. J. Harris Dew, Atlanta, announces his return from military service and the re-opening of his offices at 126 Forrest Avenue, N. E., Atlanta, for the practice of medicine. Office hours by appointment.

Dr. Charles A. Eberhart, Atlanta, announces the re-opening of his office for the practice of urology, 308 Medical Arts Building, Atlanta.

Dr. Thos. E. Fulghum, Eastman, recently discharged from the United States Navy, has resumed the practice of medicine at Eastman.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, April 9. Subject: "Public Health and Clinical Aspects," by Senior Surgeon S. J. Hall, U. S. Marine Hospital, Savannah.

Dr. Sage Harper, formerly of Ambrose and Wray, recently released from the U. S. Army Medical Corps after five years' service, announces the opening of his office for the practice of medicine at Douglas.

Dr. C. L. Ridley, superintendent of Macon Hospital, Macon, recently announced the appointment of Dr. M. M. Harris, Waycross, as chief of the clinical laboratories of Macon Hospital.

The Second District Medical Society met at the Archbold Memorial Hospital, Thomasville, April 11. Call to order by the President, Dr. Helen Bellhouse. Reading of the minutes, Dr. J. C. Brim, secretary. Announcements and introduction of visitors. Program: "Medical Thunderstorm," Dr. Ralph H. Chaney, Augusta; "Surgical Treatment of Traumatic Arthritis in the Foot and Ankle," Dr. S. Ralph Terhune, Birmingham; "Indications for Direct Laryngoscopic Examination and Bronchoscopy," Dr. W. P. Rhyne, Albany; "Undulant Fever," Dr. Chas. E. Zimmerman, Tifton; "The Diagnosis of Primary Lung Tumors," Dr. J. J. Collins, Thomasville; "Acute Upper Respiratory Infections in Childhood and the Sulfa Drugs," Dr. R. N. Joiner, Moultrie. Report of committees and election of officers.

Dr. H. B. Jenkins, Donalsonville, recently returned after more than four years' service in the Medical Corps of the U. S. Army, announces his association with Dr. H. B. Baxley, Donalsonville Hospital, Donalsonville.

Dr. J. B. Martin, formerly of Shellman, announces his association with Dr. J. S. Beard at the Beard Clinic, Edison.

Dr. W. W. Sharpe, Alma, announces the association of Dr. John Mauldin, formerly of Dahlonga, with him in the practice of medicine, Lee's Drug Store, Alma.

Dr. Robert E. Peck, Atlanta, announces the opening of his office, 2218 Peachtree Road, N. E., Atlanta. Practice limited to psychiatry and neurology. Hours by appointment.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, April 4. Program: "Dedication of the Auditorium of the Fulton County Academy of Medicine to Dr. Abner Wellborn Calhoun," Dr. James Edgar Paullin, Atlanta; "Myasthenia Gravis," Dr. Frank B. Walsh, Baltimore; "Medical Ophthalmology," Dr. Walter I. Lillie, Philadelphia.

Dr. Rufus F. Payne, superintendent of the State Tuberculosis Sanatorium, Alto, addressed the directors of the Augusta-Richmond Tuberculosis Association gathering for their annual meeting at the Georgia Power Company Auditorium, Augusta, March 27.

The Richmond County Medical Society meeting was held in the Dugas Auditorium of the University of Georgia School of Medicine, Augusta, March 19. Dr. Perry P. Volpitto, president, presided. Paper: "Intriguing Cases of Heart Diseases and Their Clues," Dr. Paul Dudley White, Boston, lecturer in medicine, Harvard Medical School, physician to the Massachusetts General Hospital.



The Seventh District Medical Society met at the Larry Bell Recreation Center, Marietta, April 3. Dr. F. H. Simonton, president, presided. "Invocation," Rev. John Tate, pastor of the First Methodist Church; "Address of Welcome," Dr. W. H. Perkinson, president of the Cobb County Medical Society; "The Oral Use of Glandular Preparations," Dr. J. K. Fancher, Atlanta; discussion led by Dr. William Harbin, Jr., Rome, and Dr. R. F. Spanjer, Cedartown; "Observations in Treatment of Battle Wounds," Dr. John M. McGehee, Cedartown; discussion led by Dr. C. B. Elliott, Cedartown, and Dr. D. L. Wood, Dalton; "Some Ophthalmological Responsibilities of the Family Physician," Dr. A. V. Hallum, Atlanta; discussion led by Dr. W. C. Mitchell, Smyrna, and Dr. H. J. Ault, Dalton; "Tuberculosis of Bones and Joints in Children," Dr. J. H. Kite, Atlanta; Discussion led by Dr. J. H. Mull, Rome, and Dr. M. Van B. Teem, Marietta. Dr. W. H. Perkinson, counselor of the Seventh District, gave a short report and informed the society that a moving picture machine was available for use by members of the district society. Officers are: Dr. F. H. Simonton, Chickamauga, president; Dr. D. Lloyd Wood, Dalton, president-elect; Dr. Inman Smith, Rome, secretary, and Dr. W. H. Perkinson, Marietta, counselor.

Dr. C. L. Ridley, Macon, City Hospital superintendent and State Health Board chairman, has been elected president of the Central Georgia Hospital Service, a non-profit hospitalization group.

Dr. John H. Robinson, III, Montezuma, recently released from the Medical Corps of the U. S. Army after more than three years' service, has resumed practice with the Macon County Clinic, Montezuma.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, April 23. The facts and findings of the Tuberculosis and Venereal Diseases Survey in Savannah were presented by Dr. C. A. Henderson, Dr. John L. Elliott and Dr. George T. Perry.

Dr. Thomas L. Ross, Jr., Macon, announces the re-opening of his office for the practice of internal medicine and cardiology, Doctors Building, 700 Spring Street, Macon.

Dr. Alfred A. Weinstein, Atlanta, announces his return to the practice of surgery and gynecology, after the termination of his services in the U. S. Armed Forces. Office 126 Forrest Avenue, N. E., Atlanta.

The Eighth District Medical Society met at the Ware County Health Center, Waycross, April 9. Meeting called to order by Dr. J. A. Leaphart, Jesup, president. "Invocation," Rev. A. G. McGinnis, pastor of the First Presbyterian Church, Waycross; "Address of Welcome," Dr. B. E. Collins, Waycross; "Response to Address of Welcome," Dr. J. W. Simmons, Brunswick. Scientific program: "Obstetrics," Dr. Tyrus R. Cobb, Jr., Dublin; "The Treatment of Traumatic Injuries," Dr. A. G. Little, Jr., Valdosta; "Address," Dr. Cleveland Thompson, Millen, president of the Medical Association of Georgia; "Inguinal Hernia," Dr. W. L. Pomeroy, Waycross; "Experiences of a U. S. A. Medical Officer in India," Dr. B. G. Owens, Valdosta. Officers are: Dr. J. A. Leaphart, Jesup, president; Dr. W. W. Turner, Nashville, vice-president; Dr. G. T. Crozier, Valdosta, secretary.

The Woman's Auxiliary of the Eighth District Medical Society met at the Paul Harley Memorial building, First Methodist Church, for the business session, which was followed by a social hour.

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the dining room, May

1. Program: "Physiology of Labor," Dr. Richard Torpin, Augusta, professor of obstetrics at the University of Georgia School of Medicine. The obstetric and gynecologic group of Crawford W. Long Memorial Hospital, and all members of the Fulton County Medical Society were invited.

The Surgical Selling Company, 139 Forrest Avenue, N. E., Atlanta, hospital, physician and laboratory supplies, announces: "Our staff has been increased by the return of Mr. Dozier P. Arnold, Mr. W. B. Brown, Mr. Thomas E. Burke, Mr. James C. Monroe, Mr. Carl Reisman and Mr. T. J. Turner, Jr., all of whom have terminated their services in the armed forces and who will strive to give you the utmost in both service and supplies."

Dr. R. L. Carter, Dr. John D. Blackburn, Dr. B. C. Adams, Dr. J. E. Garner, Dr. F. M. Woodall, Dr. J. A. Woodall, Dr. J. M. Kellum, and Dr. J. L. Bridges, the loyal and patriotic physicians of Thomaston, who gave of their time, talent and money as examining physicians on the local board of Selective Service were honored by National Selective Service Headquarters with a handsome bronze medal and a certificate of merit.

Dr. Jeff L. Richardson, Atlanta, announces the removal of his office to 1028 West Peachtree Street, N. W., Atlanta. Practice limited to cardiology.

Dr. M. K. Bailey, Atlanta, announces the re-opening of his office at 1106 Medical Arts Building, Atlanta. Practice limited to urology. Hours by appointment.

Dr. T. Luther Byrd, Atlanta, attended the Ninth Annual Meeting of the New Orleans Graduate Medical Assembly, New Orleans, April 1-4.

## OBITUARY

*Dr. James Carlton Holliday*, aged 60, one of Athens best known physicians, died March 11, 1946. Dr. Holliday was a native of Jackson County, Georgia, and a resident of Athens for 31 years. He was graduated from the University of Georgia School of Medicine, Augusta, in 1909, taking postgraduate work at Tulane University of Louisiana School of Medicine, New Orleans. He was a World War I veteran, serving as a captain in the medical corps, and for many years served as physician for the City of Athens and for Clarke County. He was past president of the Clarke County Medical Society, a member of the Medical Association of Georgia, the American Medical Association, and the First Methodist Church, Athens. Survivors are one daughter, Mrs. Edward W. Schurick; son, James Carlton Holliday, Jr.; father, Charles F. Holliday, Atlanta; three sisters and three brothers. Funeral services were held from the First Methodist Church, Athens, with the pastor, Dr. Harvey C. Holland, officiating. Burial was in Oconee Hill Cemetery, Athens.

*Dr. Melville T. Johnson*, aged 78, of 933 North Highland Avenue, N.E., Atlanta, died Feb. 15, 1946. Dr. Johnson was born in Gwinnett County and was graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1892. He practiced medicine in Lawrenceville until 1916 when he came to Atlanta. At one time he was chairman of the board of medical examiners in Georgia. Survivors are a daughter, Mrs. M. O. Weems; three sons, R. G. and Melville F. Johnson, New Orleans, and Eric Johnson of New York City; four sisters; one brother, and five grandchildren. Funeral services were held at Spring Hill and burial was in West View Cemetery, Atlanta.

*Dr. James West Meaders*, aged 86, retired Macon physician, died March 8, 1946. Dr. Meaders was born in Henry County, Alabama, the son of the late Noah K. and Elizabeth Brooks Meaders, and had lived in and near Macon for 47 years. He was a member of the Second Street Methodist Church. Surviving are three sons, J. O. Meaders, and E. H. Meaders, of Macon; W. M. Meaders, of Ocilla; a daughter, Mrs. A. R. Batchelor, Macon, 10 grandchildren, and 7 great-grandchildren. Funeral services were held in the chapel of Hart's mortuary, the Rev. T. B. Stanford and the Rev. Fred B. Hooks officiating. Burial was in Rose Hill Cemetery, Macon.

*Dr. Charles Seaborn Middleton*, aged 74, retired Blakely physician and business man, died Feb. 13, 1946. He was a native of Miller County but had lived in Early County since he was a young man. Dr. Middleton was graduated from the Atlanta Medical College, now Emory University School of Medicine, Atlanta, and practiced medicine in Early County for a period of ten years. He had served as chairman of the board of education, was a member of the city council, and represented Early County in the General Assembly for a number of years. Survivors are his wife, Mrs. Ida Lane Middleton; six sons, Curtis L. Middleton, Thomasville; H. J. Middleton, Max Middleton, Melvin Middleton, Ralph Middleton, all of Blakely; Harold Middleton, Georgetown, S. C.; and one daughter, Mrs. Lucile Loback, Blakely; one sister, Mrs. Tom Williams, Colquitt; and several grandchildren and great-grandchildren. Funeral services were held at the residence, with the Rev. W. E. Storey, the Rev. J. Alton Davis, and the Rev. W. T. Wiley officiating. Burial was in Blakely Cemetery, Blakely.

*Dr. Benjamin Ivy O'Kelly*, aged 74, well-known physician of Round Oak, died Feb. 25, 1946. He was born in Grantville and graduated from Southern Medical College, now Emory University School of Medicine, Atlanta, in 1894. Dr. O'Kelly had practiced medicine in Jones County for 50 years. He is survived by his wife, Mrs. Lillie Hungerford O'Kelly; one daughter, Mrs. W. P. Middlebrooks, Haddock; several grandchildren, four sisters, and one brother. Funeral services were held at the Round Oak Methodist Church, Rev. J. W. King officiating.

*Dr. Charles Sherman Smith*, aged 82, retired Clarksville physician, died Feb. 11, 1946. Dr. Smith was born at Douglas, Mass., and was a graduate of New York University Medical College, New York, in 1892, after which he interned at Rhode Island Hospital, Providence, R. I. Dr. and Mrs. Smith came to Clarksville in 1934. Survivors are his wife, Mrs. Augusta Gilpatrick Smith, and several nieces and nephews. Funeral services were held at the residence in Clarksville, with Rev. Clyde Lee officiating. The remains were taken to Macon for cremation.

*Dr. Charles Manfred Stephens*, aged 63, retired physician, and one of the most beloved citizens of Waycross, died at Baltimore, Md., Feb. 26, 1946. He graduated from University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, Md., in 1914, and served as intern in the York Hospital, York, Pa. In 1916 he came to Waycross as assistant superintendent of the Atlantic Coast Line Railroad Relief Hospital, later becoming superintendent. In 1922 he entered private practice in Waycross, from which he retired in 1944 because of ill health. He was a member of the Ware County Medical Society, the Medical Association of Georgia, and the American Medical Association. He is survived by his wife, Mrs. Ruth Kuhn Stephens, Waycross. Funeral services were held in Delta, Pennsylvania.

*Dr. Philip Bartow Bedingfield*, aged 84, Wrightsville, died of a heart attack at his home, March 15, 1946. A native of Jefferson County, he had spent most of his life in Johnson County, and had lived for the past 45 years at Wrightsville. Dr. Bedingfield was graduated from University of Georgia School of Medicine, Augusta, in 1887. He was the oldest living member of the Beulah Baptist Church, to which he was a liberal contributor. Survivors include his wife, Mrs. Evie Smith Bedingfield; one son, Dr. W. R. Bedingfield, Augusta; two brothers, and three sisters. Funeral services were held at the Beulah Baptist Church, with burial in the church cemetery, near Wrightsville. Services were conducted by the Rev. A. W. Franklin and the Rev. Rufus Hodges.

*Dr. James Munrow Daves*, aged 85, Blue Ridge, died at his residence April 12, 1946. A native of Fannin County, Dr. Daves moved to Blue Ridge more than 50 years ago. He was graduated from Emory University School of Medicine, Atlanta, in 1886. He was active in civic affairs, and for many years was chairman of the board of deacons of the First Baptist Church. He was a member of council and mayor of Blue Ridge for several terms; also county physician and official surgeon and physician for the L. & N. Railway. He was a member of the Blue Ridge Medical Society, the Medical Association of Georgia, and the American Medical Association. He is survived by three sons, Dr. Frank Daves, Chattahoochee, Fla.; Dr. Clint T. Daves, Atlanta; and Joe Daves, Chicago; a daughter, Mrs. Bessie Swanson, Blue Ridge. Funeral services were held at the First Baptist Church. Burial was in the Toccoa Cemetery, Toccoa.

*Dr. Arthur Paton Hanie*, aged 77, Hartwell, one of northeast Georgia's oldest and best known physicians, died March 17, 1946. He was a native of Gainesville, a son of the late Thomas Newton Hanie and Martha Morrow Hanie of Gainesville and Hall County. Dr. Hanie was graduated from Emory University School of Medicine, Atlanta, in 1891. He was a member of Hart County Medical Society, the Medical Association of Georgia, and the Hartwell Baptist Church. Surviving are two sisters, Mrs. Pearl Johnson and Mrs. Annie Strickland, both of Hartwell. Funeral services were held from the Hartwell Baptist Church with Dr. D. A. Howard officiating, assisted by Rev. Henry H. Dillard. Burial was in Northview Cemetery, Hartwell.

*Dr. George T. Kesner*, aged 83, Atlanta, retired physician, died April 16, 1946. He was graduated from University of Georgia School of Medicine, Augusta, in 1897. Dr. Kesner had practiced medicine in Atlanta for almost 42 years. Survivors include his daughter, Mrs. John B. Henry, New Orleans, and several grandchildren. Funeral services were held at the chapel of Harry C. Poole, with Dr. Harrison McMains officiating. Burial was in West View Cemetery, Atlanta.

*Dr. John Arnold Pirkle*, aged 76, eminent physician and popular citizen of Monroe, died March 22, 1946. He was a native of Jackson County, the son of the late Dr. P. P. Pirkle and Jane Smith Pirkle. Dr. Pirkle graduated from the University of Georgia School of Medicine, Augusta, in 1891, with honors, and practiced medicine in Barrow and Gwinnett counties until 1897, when he moved to Monroe. He was a member of the Walton County Medical Society, the Medical Association of Georgia, the American Medical Association, and the Monroe Methodist Church. Survivors are his wife, Mrs. Maynard Graves Pirkle; a daughter, Mrs. R. E. Aycock; a son, Mr. D. I. Pirkle; and one grandson, R. E. Aycock, Jr.; and several brothers and sisters. Funeral services were held at the home of Mr and Mrs. R. E. Aycock, with Rev. Walter S. Robinson and Rev. J. W. Segars officiating. Burial was in Resthaven Cemetery, Monroe.



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### SURGICAL TREATMENT OF ACHALASIA OF THE ESOPHAGUS

LON GROVE, M. D.

E. C. McMILLAN, JR., M. D.

*Atlanta*

Approximately 80 or 90 per cent of patients with so-called cardiospasm can be markedly benefited or cured by conservative means. It is that group who are not relieved by antispasmodics, diet and bouginage who require surgery. With the perfection of surgical technic and the use of the sulfonamide drugs, surgery might even become the more conservative rather than the radical means of treatment. We present two cases successfully treated by esophagostomy, one using the thoracic approach and one using the abdominal approach; and offering what we believe will be an improvement in the technic of anastomosis.

Achalasia is a syndrome characterized by progressive dilatation of the esophagus with functional obstruction at the cardia, in which no demonstrable lesion can be found, associated with regurgitation of food, dysphagia and pain. The numerous names given the condition (achalasia, cardiospasm, phrenospasm, preventriculosis, idiopathic dilatation of the esophagus, simple ectasia of the esophagus, megaesophagus, etc.) speak for the uncertainty of our knowledge of its etiology. That the condition is not due solely to spasm of the sphincter muscle at the cardia, as Mikulicz believed when he used the term cardiospasm, seems certain, as many investigators have been unable to show the presence

of a definite sphincter muscle. Antispasmodics have notoriously failed in the treatment of the condition, and there is no marked resistance to the passage of mercury bougies through the cardia. It was this latter observation which led Hurst<sup>1 2</sup> in 1913 to conclude that the syndrome was due to a lack of relaxation of the muscle fibers at the cardia. He believed the cardia failed to relax because of interference with nerve impulses directed at the cardia. He based his theory on the studies of Rake, who showed degenerative changes in the ganglion cells of Auerbach's plexus. Lendrum<sup>3</sup> and others have recently demonstrated a marked loss or complete absence of these cells. Some authorities maintain that the cardia is normally opened by contractions of the longitudinal muscle, and degeneration of the ganglion cells of Auerbach causes a loss of tone of the muscle. Etzel and Stinson<sup>14</sup> have advanced the theory that a chronic vitamin B deficiency causes the cell degeneration which produces this syndrome, and Stinson reports cures with massive doses of thiamin chloride. The phrenospasm theory of Jackson and Sauerbruch is chiefly supported by the observation that the esophageal dilatation begins not at the cardia but at the hiatus. Emery<sup>16</sup> emphasizes the role of psychogenic factors, while Vinson<sup>17</sup> denies that they play any part in chronic achalasia.

Achalasia is seen at all ages, though most frequently in the third decade, and affects men and women alike, though Vinson<sup>17</sup> reports it more common in white men and Negro women. Most patients have had the symptoms seven or eight years when first seen.

Read before the Medical Association of Georgia, Savannah, May 10, 1944.

The cardinal symptoms are regurgitation of food, dysphagia, and pain. It is differentiated from carcinoma and diverticulum by fluoroscopy, x-ray, and esophagoscopy. The typical x-ray picture is a markedly dilated esophagus terminating abruptly in a blunt cone at the level of the esophageal hiatus, with smooth walls, and occasionally a large S-shaped sacculation. Stasis of food produces ulceration of the wall in the more severe cases. Pulmonary symptoms are commonly associated with achalasia, due to pressure of the enlarged esophagus or to pulmonary infection from aspiration of regurgitated food. Many thousands of cases have been reported in the medical literature since Thomas Willis first described the condition in 1672. Emery<sup>16</sup> reported the incidence of hospitalized cases to be 1 in 2600 patients.

As numerous as the symptoms and theories of the cause have been, the methods of treatment are: Conservative treatment suffices for the milder cases. In addition to the use of antispasmodics and special diets, dilatation by sounds, Hurst mercury bougies, and the Russell-Plummer hydrostatic dilator, or a pneumatic modification, are advocated for the majority of cases. Hoover<sup>20</sup> reports 92 per cent good results with conservative methods. Although Vinson<sup>17</sup> states that he has never had a serious complication in over a thousand consecutive dilatations, using sounds and a hydrostatic dilator, we feel that in less experienced hands, blind forceful dilatation of the cardia is not without danger. Keller<sup>4</sup> cites several reported cases of death and some give the incidence of rupture as high as 3 per cent. In some cases the redundancy and angulation of the esophagus make dilatation from above hazardous and difficult, if not impossible. In these cases, and in those which have not been more than temporarily helped by dilatation, we believe surgery is indicated.

Ochsner, Debaquey<sup>8</sup> and Heatly<sup>11</sup>, in 1940, gave excellent summaries of the various surgical procedures which have been devised. Mikulicz is credited with performing the first surgical procedure for achalasia when he opened the stomach and manually dilated the cardia, in 1900. This operation with modifications was still being advocated by Judd, Vinson, and Greenlee<sup>3</sup> in 1929. From 80 collected cases, Ochsner<sup>8</sup> reports a mortality of 8.9 per cent from this procedure, with good results in 70.8 per cent.

A year after Rammstedt described his operation for the treatment of hypertrophic pyloric stenosis, Heller, in 1913, applied the principle in performing his extramucous cardiomyotomy. Barlow<sup>19</sup>, in 1942, reported good results from the Heller operation, advising certain simplifications.

Wendel in 1910, and Meyer in 1913, performed a successful cardioplasty, using the principle of the Heinecke-Mikulicz pyloroplasty; i.e., making a longitudinal incision across the cardia and closing the defect transversely, thus widening the lumen of the cardiac orifice. Girard, in 1915, advised doing this type of plastic operation without opening the mucosa, in order to prevent contamination. From collected cases in both types of cardioplasty, good results are reported in 93.1 per cent of cases.

Other operations, devised but performed with little success, attack not the cardia but the diaphragm (division of the diaphragmatic crura, phrenicoexeresis), the dilated esophagus (esophagoplication, excision of the wall of the esophagus) and the vagus nerves (bilateral vagotomy). Perhaps the most rational operation attacking the nerve supply is sympathectomy as advised by Knight, and with a different approach by Craig, Moersch, and Vinson, but because of the difficulty in permanently eliminating the three-fold sympathetic supply to the cardia,



these operations have met with only temporary success.

The operation which we used in the two cases presented was the Grondahl modification of Heyrovsky's esophagogastrostomy. In 1912, Heyrovsky made a simple anastomosis between the gastric fundus and dilated esophagus, short-circuiting the cardiac orifice. In 1916 Grondahl modified the procedure along the lines of the Finney pyloroplasty, thus eliminating the spur which Heyrovsky left at the cardia. Lichstein<sup>21</sup>, Womack<sup>6</sup>, Heatly<sup>11</sup>, Mitchell<sup>13</sup>, and Kredel<sup>18</sup> report good results with the Grondahl modification. Ochsner, in 1940, reported 90 cases, including two of his own, with five deaths and only one poor result. Since then four other successful cases have been reported in the literature, which with our two cases, brings the total to 96, with a mortality of 5.2 per cent. These cases could probably be operated on today with a much lower mortality rate.

We used a thoracic approach in our first case, and an abdominal approach in the second; the anastomosis being made by the same technic in each instance. With these cases for comparison, we feel that while in some cases the transpleural approach might give better exposure, the abdominal approach appears to be the safer and the exposure in general is adequate. The peritoneum is better able to take care of soiling than the pleura, though with the use of the umbilical tape around the esophagus as suggested by Fromme and advocated by Ochsner<sup>2</sup>, very little soiling is likely to occur. Adequate preoperative lavage of the esophagus is important and may require repeated lavages for several days to thoroughly empty and cleanse the esophagus. Sulfanilamide crystals are sprinkled liberally in the area of the anastomosis. We believe that the postoperative use of sodium sulfadiazine intravenously still further les-

sens the chance for peritonitis and post-operative pneumonia.

The technic of the operation which we used is that described by Ochsner as follows: A midline incision is made from the xiphoid to the left of the umbilicus. The left lobe of the liver is freed by cutting the left lateral hepatic ligament and retracted toward the right; the abdominal contents are carefully packed off. The esophageal peritoneum is circumcized at the site of its reflection onto the diaphragm and the esophagus freed circumferentially by sharp and blunt dissection, until it can be pulled three or four inches into the abdominal cavity. An umbilical tape is tied tightly around the esophagus at its uppermost portion to prevent soiling by the esophagus contents, and to hold a stay suture placed through the gastric fundus and the tape, which the friable esophagus will not stand. After placing this stay suture of silk so that the lower esophagus and the fundus of the stomach are held in apposition, a posterior layer of interrupted silk sutures is placed between the esophagus and the stomach. A U-shaped incision is made paralleling this row of sutures, the base of the U incising the cardia, the arms being in the esophagus and gastric fundus respectively. A second posterior suture line of locked 00 chromic catgut on an atraumatic needle is carried anteriorly as a Cornell stitch. An anterior row of silk is then placed to complete the anastomosis. The fundus of the stomach is tacked up to the diaphragm by a few interrupted black silk sutures to avoid traction on the suture line, and the umbilical tape is cut and removed. Six grams of crystalline sulfanilamide are left in the abdomen, and the abdomen closed without drainage, using buried sutures of fine steel wire, as tension suture.

In making the U-incision we began on the fundus of the stomach, carrying the in-

cision through the cardia and then to the esophagus. We found that, because of the difficulty in determining the site of the cardiac orifice until after the stomach was opened, we had made the incision in the stomach too long for proper approximation to the esophagus; and were forced to close the upper portion of the fundal incision before making the anastomosis. We believe if the incision is begun in the esophagus and carried through the cardiac orifice with the aid of a grooved director, this difficulty will be eliminated.

#### REPORTS OF CASES

**CASE 1**—A 29-year-old white female was admitted to Emory University Hospital on May 21, 1943. She gave a four-year history of intermittent regurgitation of food, after meals, associated with little pain or dysphagia and no hematemesis. Three weeks prior to admission she began vomiting all solid foods and most liquids and was referred to us with a tentative diagnosis of cardiospasm. She had lost an undetermined amount of weight and was unable to work because of increasing weakness, dysphagia and regurgitation.

Physical examination showed evidences of malnutrition and anemia and avitaminosis, and a widened area of mediastinal dullness. Other findings were normal.

Blood count showed moderate secondary anemia. Blood Kahn and urinalysis were negative. Esophagoscopy confirmed the diagnosis of cardiospasm. Subsequent bouginage with a No. 46 F Hurst mercury bougie gave but little relief. X-ray studies revealed a smooth-walled redundant esophagus, dilated to about twice normal size, the dilatation beginning as a smooth cone at the cardiac orifice, and no barium passed into the stomach during the entire study.

She was given a diet of strained liquids three times daily. Her esophagus was lavaged followed by injection of a solution containing 2 grams of sulfasuxidine. She was transfused with 500 cc. of citrated blood and on the morning of operation, June 2, after a twelve-hour fast, the esophagus was lavaged with 100 cc. of 0.5 per cent diluted hydrochloric acid, and the nasal tube was left in place.

Under intratracheal nitrous oxide and ether anesthesia, a Grondahl modification of the Heyrovsky esophagostomy was performed, Dr. Robert Major\* exposing the cardia through a thoracic approach.

Wangensteen suction was used and patient was given nothing by mouth for the first five days. During this time she received intravenous glucose with added vitamins, one pint of plasma and one pint of whole blood. By the ninth day she was eating a special soft diet and all intravenous clyses were omitted. Highest recorded temperature was 100.4 F. She was dismissed from the hospital on June 19, seventeen days after operation, in good condition. Weight at that time was 98½ pounds. Now, eleven months after operation, she has had no recurrence of symptoms and has gained 25 pounds in weight.

**CASE 2**—A 69-year-old white widow was admitted to Emory University Hospital on Jan. 13, 1944. Her chief complaint was regurgitation of food, which had begun in small amounts and continued, intermittently, for five years previously. Three years before admission she had had her cardia dilated at another hospital and remained in good health apparently until six weeks prior to her

present admission, when her symptoms became severe. She at times vomited food taken several days before, was extremely nervous, restless, and unable to sleep. She had lost 23 pounds of weight and was quite weak. A dull aching pain in the epigastrium and right upper quadrant of the abdomen distressed her, especially at night. She states that she had been nervous all her life.

Except for obvious malnutrition and avitaminosis, physical examination was negative. Blood count showed a mild secondary anemia; the urine, a trace of albumin; blood chemistry was normal, and blood Kahn was negative. Fluoroscopy revealed an enormously dilated S-shaped redundant esophagus, containing food debris and terminating in a blunt obstruction at the cardiac end, through which only small traces of barium passed.

The patient remained in the hospital, under medical supervision, for a month. Bouginage with olive-tipped bougies was attempted without success and Hurst mercury bougies sizes 46 to 50 F were also used but with little improvement. Operation was advised, but was refused and she was dismissed on February 10.

After a week at home she was readmitted to the hospital for operation. She was given intravenous glucose and vitamins and preoperative saline esophageal lavages twice daily. On the morning of the operation, February 25, the lavage tube was left in the esophagus.

Under intratracheal nitrous oxide and ether anesthesia, using an abdominal approach, a Grondahl modification of the Heyrovsky esophagostomy was performed.

Postoperative care was similar to that used in the first case, except the patient received daily doses of 5 grams of sulfadiazine intravenously for the first week. Highest temperature was 100 F. The patient was taking soft diet on the twelfth postoperative day and was dismissed from the hospital. She has had no recurrence of her symptoms and has gained in weight and reports that she is able to eat a normal diet.

#### Summary

The various theories of the causes of achalasia of the esophagus have been mentioned. The incidence, symptomatology, and diagnosis have been discussed briefly; and a summary given of the various types of surgical procedures which have been used in treatment.

Two patients treated by esophagostomy have been reported, a thoracic approach being used in the first case; an abdominal approach in the second. We favor the abdominal approach because we believe it safer.

A variation in technic of anastomosis, which we believe will be an improvement, has been suggested; namely, that the incision begin on the esophagus and be carried through the cardiac orifice with the aid of a grooved director in order to accurately determine the position of the cardia before the incision is made in the fundus.

Since this report we have successfully operated on the third patient with achalasia of the esophagus using the same technic, through an abdominal approach. The patient has been well since.

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## CANADIANS AND AMERICANS MEET

The Canadian Medical Association will meet in joint session with the American Pharmaceutical Manufacturers' Association on the evening of June 10, at the Banff Springs Hotel, Canada, where the CMA is convening concurrently with the APMA's convention at nearby Lake Louise.

It is believed this marks the first formal joint session anywhere of associations representing the pharmaceutical manufacturers and the medical profession they serve.

Informality, rather than formality, however, will be the rule of the evening. After short welcoming speeches by the CMA and responses by the APMA, the doctors will play host to the drug makers on an informal tour of the medical exhibit and the evening will be concluded with refreshments.

As was previously announced, the Canadian Pharmaceutical Manufacturers' Association will also meet jointly with the American pharmaceutical manufacturers, collaborating in the APMA sessions at Lake Louise from June 10-12.

The fact that the APMA is holding its annual convention for the first time on Canadian soil offers a happy opportunity for these joint sessions at Banff and Lake Louise. They not only emphasize the mutual interest of the participating associations but also testify to the fine spirit of cooperation between the two countries they represent.

## POSTINFLUENZAL VIRUS PAIN COMPLEXES

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*Atlanta*

Since 1939 the majority of physicians must have observed an increase in the number of patients complaining of various aches and pains, likewise have been perplexed as to the cause and persistence of such symptoms without evident pathologic changes. This has been my experience, and as new cases of pain continued to seek relief, there came insight and understanding of the disease of widely dispersed and apparently unrelated phenomena. It is the purpose of this article to give the reader an understanding of these pain complexes viewed in the light of virus origin. Laboratory investigation will yield most fruitful findings that will clarify the many symptoms following respiratory infections, commonly designated as colds, sore throat, sinus infections or influenza. The data upon which these observations are based were obtained from private patients studied at my office during the past three years. There were about 300 cases in the group comprising 100 cases of low back pain (lumbar region) and 200 upper spinal tract cases.

Pain in a given body area most commonly brought in patients for treatment, although many came to obtain relief from fatigability and asthenia. Careful inquiry in each case brought out the history of a previous influenzal or respiratory infection, characterized by proneness to relapse, prolonged duration, slow recoverability, and ineffectual treatment response. Frequent and recurring bouts of cough or sore throat, nocturnal sweating, anorexia, loss of weight (6 patients lost 30 pounds), insomnia, tingling extremities, and lack of energy were the other common complaints. Such complaints were common over periods of from six to twenty months. If the patient

did not complain of having a cold, sore throat, cough, sinus infection or postnasal drip, one could elicit a history of migratory pain in various segments of the spinal cord. (This is in keeping with the findings of Beeson<sup>1</sup> and Scott<sup>2</sup>, in their report of a study of cases among a group of factory workers). These cases differ from Bornholm disease (epidemic pleurodynia) in that there is a lack of diaphragmatic pain and lack of headache.

The pharynx usually presented the only part in which the examiner could see an abnormality. The soft palate, tonsillar pillars and post pharynx present characteristic salmon pink injection. The regions may be slightly swollen, glossy, and edematous; occasionally a tiny superficial ulcer with a greyish white base is observed in a streak of injection. These throats look very different from those of acute follicular tonsillitis, acute scarlet fever or a streptococcal throat. In some only the pillar had a pink streak extending up into the hard palate or even to the gum about the third molar, yet these patients complained of severe angina. Such a throat may be comparable to smoker's throat.

The next important finding, lymphadenopathy, is only recognized by the finger tips and is common to all these cases. The most commonly enlarged glands are in the anterior and posterior cervical groups; at times the postauricular, supraclavicular, or suprascapular chains are definitely enlarged. Tender nodes at any point along the entire spinal, the sacroiliac or postsacral regions may be felt at the spinal emergence into the back of the cutaneous nerve supply to the tender and painful area in question. The area, which must be carefully palpated, is indicated by the patient's complaint of pain in a given area: i.e., for earache, palpate the postauricular chain; for torticollis, the postcervical; for inter-

costal pain, feel along the spine, one inch lateral to the midspine line, at the emergence of the dorsal root supplying the area, and for low back pain (lumbago) one should palpate for lymph nodes over the spino-pelvic joints from the posterior-superior iliac spine downward and inward to the coccyx. The finger tips can find these lymph nodes and pressure on such tender areas reproduces the pain of which the patient complains.

X-ray and fluoroscopic examinations of the chest were routinely done. In many of the 300 cases there was an increased hilar and peribronchial lymph density. Mediastinitis was observed in 5 cases. X-ray findings are only suggestive and not diagnostic. Eleven cases with severe cough showed reaction zones typical of virus pneumonia. Six patients had hemoptysis. There were 13 cases of bursitis of the shoulder, elbows, knees and ankles. Associated with these was a myxedematous swelling of the lower extremities or the hands. Only lymph stasis and lymph angitis could have explained these swellings.

For twenty years special study of lymphogranuloma venereum has made me observant of lymph gland disease. As one compares the lymphadenopathy of lymphogranuloma venereum, infectious mononucleosis, mumps, and rubella to that exhibited in this infection, it becomes evident that the agent producing this disease must be close kin.

From such a deduction one concludes this to be a virus disease. Further evidence for this assumption is obtained from the lack of response to the sulfonamides. Twenty patients were observed who developed an influenzal-like infection while taking sulfathiazole for other infections, and in whom various pain complexes consequently occurred. In these the possibility of drug fever was eliminated.

It is a logical assumption that this virus



is neurotrophic as well as glandulotrophic. At this time it is well to define my stand for a hypothesis of which I have not the slightest demonstrable proof. Only by comparing this entity with the other virus diseases could these cases be explained and understood. In poliomyelitis the anterior spinal horns are affected with resultant paralysis, whereas in herpes zoster the virus attacks the posterior roots, and the cutaneous nerve fibrils degenerate. So it appears that this virus attacks certain fibers of the dorsal nerve roots as in herpes. As these cases were studied, each one presenting different pain symptoms, it was evident that the autonomic nerve system must be affected, otherwise it would not be possible to explain symptoms ranging from the eye and ear (superior cervical ganglion) to the lumbar region (lumbar ganglion). Albert Kuntz<sup>3</sup> has shown most eloquently the relationship of the autonomic system to the spinal system. Davis and Pollock<sup>4</sup> give confirmation of the transmission of pain through efferent fibers passing through posterior roots. Such mechanisms are operative in these cases. In some manner the virus produces stimuli that are carried over such pathways. The sensory branches only are affected; destruction of the nerve structure does not occur, so vesicles of the skin do not form at the nerve termination. Unlike herpes the pain may continue for months, as was exhibited by 5 cases of severe and prolonged (six to twelve months) neuritis of the entire right arm, in which the patients could not elevate their arms in order to drink water, comb their hair or remove their hats. These arm cases likewise presented hyperesthesia of various cutaneous arm areas, enlarged supraclavicular, axillary and suprascapular lymph nodes as well as a nonpitting edema of various parts of their upper extremities.

Many objections may be voiced to such deductions relative to nerve disease in

which biopsy and pathologic study were not undertaken, but none of these patients was willing to submit to such a study. Lymph nodes were studied, but such sections neither proved nor disproved a virus inflammation. These cases probably had in addition to lymphangitis, inflammation in the fascia, tendon sheath, the muscles and even fatty tissue as well as bursa evidenced by distention. From the 300 cases encountered, it appears that the lymph system was the common host retaining the virus and for some peculiar reason it seemed to localize in a particular posterior nerve root to be dislodged only with difficulty. All the members of a given family have succumbed to this infection, as similarly occurred in the influenza epidemic of 1918. Their respiratory symptoms varied, but they subsequently developed sequella of pain. Careful analysis of each case revealed that arthritis could be eliminated from the diagnosis and neuritis or neuralgia given. This is in agreement with Bates, Judovitch<sup>5</sup> and Carnett<sup>6</sup>.

Further it appears that this is a new infectious agent (virus) coming to Georgia, or at least becoming activated about 1938 when so many cases of virus pneumonia developed. This was the time of the innovation of sulfonamide therapy. Could the prolonged, indiscriminate, and frequently repeated use of the sulfonamides upset the equilibrium between virus and host whereby a simple, innocuous agent acquires greater activity and force? The price of bacterial cure is increased virus activity. This virus has been referred to as virus X, virus pneumonia, cat fever, severe common cold, Jap flu, and by other terms. By way of comparison, it has characteristics common to the agent of infectious mononucleosis, herpes zoster, the 1918 type of influenza, and lastly of the common cold. Indeed it may be the virus of the common cold in new guise, a military uniform with arma-

ment and weapons to make it a more formidable foe. Such an attitude permits one to understand the common lay assumption of a cold settling in the back, leg, arm or neck. It may throw light on intestinal flu and why so many blood, urine and stool cultures and other laboratory tests are negative in some of the fevers of unknown origin; it further tells why in the past so many patients sought relief from osteopaths and masseurs, or else became neurotic after being told there was nothing wrong with their back or neck.

Synopsis of classification and descriptive notes of observed cases:

1. **VISUAL:** Changes in acuity, fatigability, blurring transitory reddening and lacrimation, photophobia, supraorbital and postorbital pain.

2. **AUDITORY MASTOID:** Earache, throbbing, intense, recurring pain around ear, tenderness of skin over mastoid. Tympanic membrane normal and no subsequent signs of otitis media. Pain over mastoid is superficial and temperature is flat.

3. **FACIAL:** Simulates mumps but very little swelling. Similar reaction to sour and sweets, sublingual and submaxillary glands may be as large as in mumps, no suppuration of glands. Pain may originate over mandibular joint. Pressure with fingers accentuates pain.

4. **SINUSITIS:** Commonly implicated, X-ray negative. No purulent discharge. Chief complaint may be pain over any sinus. Fails to respond to treatment. Toothache is common.

5. **NECK GROUP:** Torticollis, pain in any part of neck, local areas of tenderness, stiffness. Motion accentuates or precipitates pain. Radiation of pain into chest and arm.

6. **THORACIC:** Pleurodynia, intercostal neuralgia. Pain follows distribution of an intercostal nerve. Coronary; pain radiation simulates infarction. Movement of arm or chest initiates pain, no other cardiac symptoms. E.K.G. normal. Sudden movement, such as bending over or thrusting the arm outward, may bring forth such pain. Pain may persist many months. Pain and local swelling elsewhere in body.

7. **BRACHIAL PLEXUS:** Hypersensitive areas in regions of so-called referred pain are not present in true coronary disease. Pain may be in entire arm or in any part. Pain develops on motion and inhibits normal function, radiation from the neck downward; bursae of shoulder, elbow and wrist may enlarge and show localized tenderness and warmth.

8. **ABDOMINAL:** Parietal neuralgia, findings dependent upon nerve supply. Hypergastric suggests diaphragmatic pleurisy or gallbladder disease. Eighth to tenth dorsal right simulates appendicitis. Twelfth dorsal to third lumbar nerve suggests pelvic, bladder, or intestinal disease.

9. **LUMBAR REGIONS:** Sacroiliac, lumbosacral, supraspinous regions. Bending, rotating pelvis produces pain. Patient has a desire to laugh and cry simultaneously. Deep pressure reveals localized tender areas over lumbar and sacral regions. Involvement of third, fourth and fifth lumbar and sacral nerves gives low back pain and leg symptoms.

10. **LOWER EXTREMITIES:** Pain most frequently like sciatica; growing pain; knee, calf or ankle pain. Swell-

ing of ankles or entire lower leg, tinglings and sensation of fullness. As in other nine groups patient has feeling that if it were possible to insert hand in spine, neck or back and move a part to a different position all pain would stop. Posture and radiation show it not to be a ruptured disc. Virus infection is much more frequent than ruptured disc or cord tumor.

Blood examination may reveal nothing. There may be a relative leukopenia, and after months there is a marked drop in the total red cells and in the hemoglobin. Other blood findings are not significant.

Recurrences or recrudescences are very common. It appears that most cases become chronic, particularly with tendencies toward anemia. Chilling, heat losses, donation of blood, climatic changes all have an influence on reactivation of the virus, as evidenced by hyperpyrexia, sweating, post-nasal drip, angina, cough or development of a new pain.

In retrospect, many cases of unexplained pain formerly described as arthritis of the spine revealed no joint disease. X-rays of the spine were negative. It is more appropriate to designate these as a neuritis or myofibrositis of virus origin. Many patients classed as neurotic, malingering, or as having a railroad spine or a sacroiliac sprain have been misdiagnosed. Trauma is supposedly the direct cause of such sprains; but even though mild trauma occurred, the fascia, nerve fibril, or synovial membrane were previously infected with the virus, and the trauma or sprain merely produced a spread of the infectious agent.

The recent report of Butch and Harber<sup>7</sup> describing 50 cases of acute virus infection with nerve root involvement simulating appendicitis will illustrate the findings in my cases. Sheppe, Osterman, Ahroon, and Zuflacht<sup>8</sup> describe a case of menigomyelitis of virus origin in which quite definitely the infectious agent first gave respiratory symptoms with subsequent nerve invasion, showing again the neurotrophic tendencies of the virus in their case. Burnett<sup>9</sup> discusses qualities and potential-



ties of virus diseases that are not usually mentioned by writers; e.g., that the virus may be present in the animal host during the entire lifetime. For instance, in herpes labialis in humans and psittacosis in parrots, there is a balance between host and virus. Both live in the same body. Fever displaces the virus from a hidden recess to lip surface. J. B. Carnett<sup>10</sup> as early as 1926 described intercostal or parietal neuralgia. Very little attention, however, has been given to this subject by the medical profession. Any physician regardless of his specialty would do well to give it consideration.

The seven Carnett mechanisms of testing for parietal neuralgia were employed in the examination of those patients having involvement of the abdominal wall; in other spinal segments all seven tests cannot be applied.

X-Ray incidence of spinal arthritis was found in many cases. The arthritis has nothing to do with the pain. The condition is related to the nerve and lymph tissue.

In the treatment of these various pain complexes one must attempt to assist the natural recuperative abilities, for no specific remedy has ever cured a virus disease. Bed rest and physiologic rest of the affected part are necessary in the acute phase of pain and fever.

Local heat is most helpful. Diathermy is of little value. The production of hyperpyrexia by injections of vaccine or foreign protein; i.e., boiled milk, is helpful in most cases. Three to four injections at weekly intervals suffice. Soluble iodine or potassium iodide is of much value. Sodium iodide by vein may help some patients. The sulfonamides are of no value. Early massage may do harm by spreading the infective agent and causing chronicity. Iron and vitamin therapy for anemia are necessary in all cases.

Relief to the majority of patients is brought by the use of sodium cacodylate given intramuscularly, two to three times weekly for twelve doses, in conjunction with vaccine, iodine, iron and vitamins.

For those with obstinate pain an injection of a mixture of drugs has proved quite satisfactory. The injection comprises 1 cc. (50 mg.) of thiamine, or 1 cc. of vitamin B complex with 1 cc. of solution of pitcher plant (the insect devouring swamp lily, *Sarracenia Purpurea*) and 5 cc. of 1 per cent novocaine; 1 to 3 cc. are dispersed in and around the painful nerve area, or given in similar fashion to a paravertebral nerve block. If this procedure is repeated twice weekly for two weeks, the pain is lessened and its duration shortened. If relief is not obtained, 0.5 cc. of typhoid vaccine may be added to the above mixture and several more injections given. Such injections into tender areas give results that are remarkable and spectacular at times, particularly in the relief of low back pain. Injection of a vaccine into the painful back produces severe pain for 36 hours, but the local heat and reaction produce subsequent relief and shorten the disability. Novocaine alone proved ineffective. The use of a sacroiliac corset (health belt) for low back pain gives much relief and enables the patient to resume usual activities but does not cure him. Accelerating the metabolic rate in persistent painful spines or backs by giving one or two grains daily of thyroid extract is worthy of trial.

The results obtained by injection are at times spectacular. Injection of those tender areas shortens the course and offers more relief to the victim of neuritis than any other method of treatment.

These pain complexes are so common that they are encountered by all physicians in their daily practices, and the use of the injections herein described may relieve un-

told suffering and save many hours of disabilities.

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## SUBTOTAL RESECTION OF THE PANCREAS OF AN EIGHT-YEAR OLD CHILD FOR HYPERINSULINISM

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*LaGrange*

Following the discovery of hypoglycemia and its cause by Dr. Seale Harris in 1923, many cases have been found and reported. The great majority have been amenable to treatment by dietetic methods, but a number of cases not responding to a proper dietetic regimen have been treated surgically. The surgical treatment has consisted of either the removal of a carcinoma or adenoma of the pancreas, or a subtotal resection of this organ.

For hypoglycemia to be amenable to surgical treatment it must be caused by hyperinsulinism. Therefore, every cause of hypoglycemia other than pancreatic disease should be considered and eliminated. The final diagnosis of hyperinsulinism can be made only by blood sugar studies. These

studies should be carried through a six-hour period if necessary. Dietetic treatment of the patient should always be given a trial before surgery is considered.

The case which I am reporting is of especial interest because of the age of the patient. It is very probable that many cases in children are improperly diagnosed as brain tumors, epilepsy, or other diseases, and are allowed to go to a fatal termination when a correct diagnosis could easily have been made by blood sugar studies, and a cure obtained by proper dietetic management or by surgery.

#### REPORT OF CASE

On April 22, 1939, D. E., a male white child, aged 8 years, was brought to my office by his parents, who stated that he frequently fainted and that at times he had convulsions. The history of fainting spells was of more than a year's duration. The convulsive attacks had been occurring for several weeks. The child was nervous, undernourished, and uncommunicative. His size and development were that of an average 6-year-old child. A routine physical examination, including hemoglobin estimation, white and red blood cell counts, and urinalysis, showed nothing unusual. A further study including blood chemistry was advised. Since the parents' home was in Lanette, Alabama, his father asked if these studies could not be made by someone nearer than LaGrange. He was referred to Dr. R. P. Morrow of West Point, an excellent diagnostician and who is very much interested in glandular and metabolic disturbances. After gaining the child's confidence, Dr. Morrow was able to obtain an excellent history. The boy said when his attacks first started he could prevent fainting when he felt weak by drinking a soft drink or eating candy, but that recently if he ate candy, a few hours later he would have a convulsion. Following the convulsion, he was nauseated and vomited. This accounted for his malnutrition.

Dr. Morrow verified this history by giving him glucose when he complained of faintness. He was temporarily relieved, but had a convulsion a few hours afterwards. A glucose tolerance test showed 0.060 fasting blood sugar; 0.120 one hour after administration of glucose, 0.050 the second hour, 0.023 the third hour. Almost immediately after this the patient had a severe convulsion. There was no improvement shown when the patient was placed on a proper dietetic regimen. After a telephone consultation with Dr. Seale Harris, Dr. Morrow advised surgery. Dr. Harris advised me to remove all but the head of the pancreas if no adenoma was present.

On May 11, 1939, the operation was performed at the Valley Hospital in West Point, Georgia. As certain steps in the technic used by me in this and other cases differ from the operation as usually described, and are of considerable importance, the technic will be described in detail.

The abdomen was opened by an upper left paramedian incision. The omentum was turned back and the lesser peritoneal cavity entered by incising the transverse mesocolon in an avascular area. The pancreas was carefully examined and no tumor was present. The peritoneum covering the pancreas was carefully incised from the neck to the tail and dissected upward and downward. Starting near the neck, the splenic artery was carefully dissected from the pancreas and retracted upward, all communicating vessels being clamped before being di-



vided. The splenic vein was now brought into view by retracting the pancreas down and its branches from the pancreas were clamped and divided. By carrying out this procedure, the splenic vessels and the spleen were isolated from the pancreas. Below, the few small communicating vessels to the renal artery and vein were handled in the same manner. In this case there was a small aberrant vein connecting the splenic and the renal veins. This vessel crossed the pancreas about one inch from its end. This was clamped close to the large veins and the midportion resected. Ligatures were applied and all clamps removed. The tip of the tail now lifted easily and as there are rarely more than a few small vessels entering and leaving the pancreas posteriorly, sharp knife dissection was used to elevate the organ from tail to neck. If the pancreatica magna is present it can be seen and clamped. In this case only one bleeding point was encountered and this was easily clamped. This sharp dissection prevents trauma to the underlying plexus and lessens shock materially. The pancreas was then divided, leaving only that part within the curve of the duodenum. Excessive fishtailing was avoided so as to minimize the possibility of pancreatic leak. The pancreatic duct and vessels were clamped and ligated. The stump of the pancreas was closed with mattress sutures. The peritoneum was closed over the stump. A small cigarette drain was placed so as not to be in contact with the stump of the pancreas. The meso was sutured around the drain, which was carried out at the lower angle of the wound. The abdominal wound was closed in layers. While the patient was recovering from the anesthetic, he partly removed his dressing and completely removed the drain. His postoperative course was uneventful. All urine specimens were examined for sugar and none was present. Patient was discharged from the hospital May 27, 1939, in excellent condition.

As soon as the pancreas was removed, it was sliced in thin slices and dropped in formaldehyde solution to prevent autodigestion. The tissue, examined by Dr. Jack Norris of Atlanta, showed a marked hyperplasia of the islands of Langerhans.

After being dismissed from the hospital, the patient's urine was frequently checked and no sugar was found. A glucose tolerance test was run three months after the operation and was normal. Tests run in 1940 and 1942 were also normal.

The patient has not had a convulsion since the operation. His growth has been progressive, but he is small for his age. In October, 1942, his parents brought him to me, stating he fainted when he went to school. He was admitted to the City-County Hospital in LaGrange. Glucose tolerance tests were normal and, on a free carbohydrate diet, his urine showed no sugar. On the third day of hospitalization, he volunteered the information that his fainting spells were "put on" to get out of school. He was dismissed from the hospital.

In the summer of 1944 the patient worked for a drug store in LaGrange and I saw him and talked with him frequently. He is active, bright, and healthy. He has not had any fainting spells since his discharge from the hospital in 1942.

### Conclusions

This report presents the successful treatment by surgery of an apparently hopeless case of hyperinsulinism in a child.

The method here described of handling splenic vessels simplifies the operation and lessens the risk to the patient.

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### A. M. A. SURVEY SHOWS INCREASE IN HOSPITAL ADMISSIONS IN '45

*Baby Born In Hospital Every 16 Seconds;  
Tuberculosis Sanatoriums Report  
Drop In Number of Patients*

During 1945 one patient was admitted to a hospital in the continental United States every 1.9 seconds and a live baby was born in a hospital every 16 seconds, according to the 25th annual report of the Council on Medical Education and Hospitals of the American Medical Association.

F. H. Arestad, M. D., and M. G. Westmoreland, M. D., present the Council report in the April 20 issue of *The Journal of the American Medical Association*. Their figures reveal that in comparison with 1944 the number of hospital beds has increased from 1,729,945 to 1,738,944, the number of admissions from 16,036,848 to 16,257,402, the number of patient days from 475,607,484 to 512,915,155 and the number of hospital births from 1,919,976 to 1,969,667.

Represented in the report are 6,511 hospitals registered by the American Medical Association, including 1,156 hospitals approved for internships and residencies and 2,625 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals totals 100 less than reported in 1944.

Both governmental and nongovernmental hospitals showed a slight increase in bed capacity last year, the government group reporting 1,356,718 or 78 per cent of all beds, the nongovernmental hospitals 382,226 or 22 per cent. The federal hospitals which expanded rapidly during the war had a net loss of 4,751 beds compared with 1944.

In the present survey the general hospitals reported 922,549 beds as compared with 925,818 in 1944. This represents a net decrease of 3,269 whereas the previous year showed an increase of 75,242. With their present facilities the general hospitals have 53 per cent of all beds.

There were 16,257,402 admissions exclusive of out-patients and newborn infants in 1945. This is the equivalent to 12.3 per cent of the total population according to the U. S. Census of 1940. Since 1935 the admissions in the hospitals registered by the American Medical Association have more than doubled in number. The greatest annual gain occurred in 1943 when an increase of 2,829,088 was reported. The following year showed an increase of 662,150 while the present survey indicates a net gain of 220,554 in comparison with 1944.

The governmental hospitals with 78 per cent of the bed capacity reported 6,399,113 admissions or 39 per cent of the patients admitted in 1945. The nongovernmental hospitals which received 61 per cent had 9,858,289. Both groups showed a substantial increase in hospital admissions in 1944 but in the present survey the gov-

ernmental hospitals showed a net loss of 146,107 as compared with the previous year.

General hospitals supply the greatest volume of hospital service in the United States. Last year they admitted 15,228,270 patients—93.6 per cent of all admissions—and maintained an average daily patient load of 665,105. In addition they gave care to 1,907,772 newborn infants, 96.8 per cent of all live births reported in the registered hospitals in 1945. The nongovernmental general hospitals had a total of 9,371,874 admissions, the federal general hospitals 3,898,995 and the other governmental general hospitals 1,957,401.

The mental hospitals with 37.7 per cent of all beds had 248,876 admissions or only 1.5 per cent of the total patients admitted in 1945. In comparison with 1944 there was an increased number of mental patients admitted in all non-governmental groups. The mental hospitals under state, county and municipal control showed a slight decrease, but the federal division reported an increase of 13,147. The total gain in relation to the previous year was 22,483.

The tuberculosis sanatoriums showed a continued decrease in the number of patients admitted as evidenced by the present report of 86,186 admissions as compared with 88,281 in 1944.

The enormous volume of service rendered by hospitals in the United States is likewise reflected in the daily patient load, which averaged 1,405,247 in 1945 exclusive of newborn infants. For the first time also the daily census in general hospitals exceeded the patient load of the mental institutions, the latter reporting an average of 624,349 as compared with 665,105 in the general hospital section. In the previous year the corresponding figures were 618,951 and 570,331 respectively.

For the period represented in this report the registered hospitals in the United States had 13.2 beds per 1,000 population. The actual utilization of hospital beds, however, as determined in relation in the average daily census, was 10.6 beds per 1,000 population.

The governmental hospitals reported 315,149 births in 1945, the church related hospitals 665,153, the other non-profit associations 793,220 and the proprietary institutions 196,145. The comparative figures for 1944 were 293,424, 652,761, 773,489 and 200,302 respectively. Last year the increase in hospital births was 49,691 whereas the previous year showed a decrease of 4,615. In 1942 and 1943, however, increases of 265,659 and 253,992 were reported.

Registered hospitals reported employing 144,724 graduate nurses exclusive of 25,277 private duty nurses during the latter part of 1945. The corresponding figures for 1944 were 125,458 and 23,949.

In connection with the present survey, state accredited schools of nursing reported a student enrolment of 130,909 as compared with 129,879 in 1944 and 110,222 in 1943.

## MALARIA "BLOCKBUSTER" IN WAR ON NEUROSYPHILIS

Malaria is being used as a "blockbuster" in the war on syphilis of the brain and spinal cord, according to an article appearing in the current issue of *Hygeia*, health magazine of the American Medical Association.

The authors, Lieut. Col. Hilton S. Read, Major Frederic T. Becker, and Capt. Lawrence I. Kaplan, Medical Corps, A. U. S., who are on the staff of the Army's Finney General Hospital in Georgia, write that even early syphilis treatment is no guarantee against neurosyphilis.

"Four years after the appearance of the primary sore, 30 to 50 per cent of infected cases may develop neurosyphilis, the most stubborn form of the disease. Why spirochetes choose to attack the brain and spinal cord is still undetermined. One theory suggests that inadequate, interrupted or inefficient treatment increases the chance of involvement of the nervous system; however, the development of neurosyphilis may follow even excellent treatment."

Artificially induced malaria treatment was first tried on a large scale in 1917. Since that time it has become a widely used method of therapy.

Continuing they say:

"In 97 per cent of neurosyphilitic patients to whom malaria is administered early in the disease, arrest is possible before the crippling of minds and nerves takes place. Fever alone does not seem to be the answer. The thermal death point of the spirochete is 114 F., a temperature no human being could survive. The mystic seat of body immunity—a group of cells in the liver, spleen, lymph glands and bone marrow—may eventually provide the explanation for the beneficial action of malaria. Research experts, like Mark F. Boyd, M. D., of the Rockefeller Foundation, believe that after the bite of the malaria-infected mosquito, the malaria parasites rendezvous in these cells. The blood of a person who has been bitten by an infected mosquito may be safely used for transfusions several days after the bite without danger of transmitting malaria to the recipient. In other words, the malaria parasite has retired to some unknown retreat, considered by some to be located in the group of cells governing immunity to disease.

"During this period the parasite may be undergoing development until it matures to the stage at which it can invade, live on, and destroy the red blood cells, thus causing chills, fever and anemia, the typical symptoms of malaria. One by-product of this development to full growth may be a stimulation of the immunity-producing system, with a resultant increase in resistance to such a deadly foe as the spirochete of syphilis."



# PRESIDENT'S PAGE

## WE MUST BATTLE TOGETHER

New names and new faces appear as the years go by, but even though a new name is appearing on the President's Page this month I am hopeful that a "New Deal" is not appearing.

The present wave of discontent which is passing across the country, involving labor and the social conditions which underly economic life and well being of the community as a whole, strongly indicates that all the trends and isms that the "dogooders" would force on the medical profession are only part and parcel of the common emotional unrest, and that medicine was simply one of the easiest and most spectacular points of primary attack.

Even though from the present outlook there is little probability of the Wagner-Murray-Dingell Bill reaching the floor of either house of Congress during the present year, that assurance does not permit us to slacken our efforts to combat its passage and adoption when it does come up at a later date, *as it surely will*.

From our own standpoint I believe that we must plan to attack the issue from two points of view. The first demands continuous and persistent educational effort on the part of the entire medical profession and its related bodies, such as the Auxiliary, to inform the general public as to the exact meaning of these measures and what their passage will mean to them. The second demands that we, as rapidly as possible, fall into line with the general policy of the American Medical Association and make voluntary prepayment medical care possible in Georgia on a county and state-wide basis.

We have too long, because we are constantly busy, said, "This cannot happen to us". However, now that it is at our door, we must take up the fight with the same degree of effort and enthusiasm that we would enter the fight against any epidemic scourge which struck within our community.

If we battle together we will win; if we are divided we will fall!

RALPH H. CHANEY, M.D.

# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

JUNE, 1946

## STEVE PASCHAL KENYON, M.D.

Dr. Steve Paschal Kenyon, of Dawson, was elected President-elect of the Medical Association of Georgia at its Ninety-sixth Annual Session, held in Macon May 7-10, 1946. The son of Dr. Owen Thomas Kenyon and Myra Kimbrough Kenyon, he was born at Weston, Webster County, Georgia, July 18, 1890. In 1900 the Kenyons moved to Dawson, Terrell County, Georgia.

Early in life Steve Kenyon made up his mind to obtain a good education. He attended regularly the public schools of the City of Dawson, and in the spring of 1908 graduated from Dawson High School. A few months later he matriculated at Mercer University, Macon, where he continued his studies and where he was awarded the Bachelor of Arts degree in June, 1912. At Mercer he was elected a member of Sigma Nu Fraternity.

After his graduation from Mercer University he sought a teaching position, and soon was a member of the faculty of Gainesville High School, Gainesville, Georgia, where he stayed for two years, becoming the principal of the school in 1913. In addition to his administrative and teaching duties at Gainesville, he was coach for all the school's athletic activities.

In the fall of 1914 he became a member of the freshman class of the newly-created medical school of Emory University, Atlanta, and in June 1918 was awarded his Doctor of Medicine degree and an honorary certificate by that institution. At Emory he was elected to membership in Phi Rho Sigma and Asklepios medical fraternities, and in 1917 he was the editor-in-chief of the medical school's annual publication—Aesculapian. With the coming of World War I and the effort by all groups to mobilize for a successful early termination of that war, he was an active member of the Medical



STEVE PASCHAL KENYON, M. D.  
Dawson  
President-Elect 1946-1947

Enlisted Reserve Corps of the United States Army.

After Dr. Kenyon's graduation from Emory he served internships at Wesley Memorial Hospital, Atlanta, and at Charity Hospital, New Orleans. Later he did graduate work at Harvard Medical School, Boston.

For the past twenty-five years he has been a general practitioner of medicine in his home city and county. In his busy life of rendering medical care to the people of his community, he found some time for other activities: He has served as city physician for the City of Dawson, as county physician for Terrell County, as alderman for the City of Dawson, as chairman of the school board for Dawson's public schools, as commander of the Davis-Daniel Post of the American Legion, as president of the Rotary Club of Dawson, as chairman of the Terrell County Department of Health, as director of the Bank of Dawson, and as dea-



con of the First Baptist Church of Dawson. In addition, he has participated in the affairs of the Masons, the Knight Templars and the Shriners.

Dr. Kenyon has long been interested in organized medicine. A member of the Terrell County Medical Society, he was elected president of that organization early in his medical career. Later he was elected president of the Third District Medical Society. Still later he was elected a member of the Council of the Medical Association of Georgia, having been its chairman during the past few years. Since 1939 he has been a member of the Georgia State Board of Medical Examiners, and was chairman of that body in 1942-43.

Well qualified for the position to which he was elected in the Medical Association of Georgia, and with the backing of his fine family—consisting of a wife and two daughters—Dr. Kenyon will be most helpful in solving some of Georgia's medical problems of today. In the years that follow a war there are many old problems made new, some of which become troublesome. In the liquidation of these problems, even though troublesome, he will exercise good judgment and will, with the help of all members of the Association, do those things which will benefit medically the most people.

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## CANCER OF THE RECTUM

It is necessary to stress the frequency of cancer of the rectum. More than 5 per cent of all neoplasms of the entire body occur in this region. Two-thirds of the cases of carcinoma of the colon can be felt digitally by rectal examination, or seen and biopsied through the sigmoidoscope. It is not difficult to diagnose if these two procedures are carried out routinely by the physician on routine check-up examination. The value of periodic rectosigmoidoscopic examination in the prevention of lower bowel malignancy is now being advocated.

Bleeding is the most frequent complaint that brings the patient with rectal cancer to the doctor. Every case should be considered cancer until proven otherwise. While the most frequent cause of rectal bleeding

is hemorrhoids, this should not be treated first on the basis of the law of averages. Certainly no injection therapy nor anorectal surgery should be undertaken before a sigmoidoscopic examination has ruled out neoplastic disease. This should be routine, as not infrequently cases of rectal cancer have been subjected to hemorrhoidectomy.

Any change in the bowel habits of a patient, particularly after the age of 40, should be viewed with suspicion, if not alarm, until malignancy is ruled out.

Cancer of the rectum is usually adenocarcinoma arising from the columnar epithelium, frequently from the base of a polyp. In its earliest stages it is limited to the mucosa and the submucosa. Later there is invasion of the muscular coats and the disease spreads to the mesosigmoid glands, and lastly to the liver. Anal cancer or epithelioma, having an incidence of only 10 per cent, spreads to the inguinal lymph nodes. Miles<sup>1</sup> in 1908 based his abdominoperineal resection on the fact that the spread of carcinoma was upward, laterally and downward. Pathologic studies by Westhues<sup>2</sup> in 1934, and by Dukes<sup>3</sup>, Collier<sup>4</sup>, Gilchrist<sup>5</sup> and David<sup>5</sup> since that time have refuted the importance of the downward and lateral spread.

Therapy is naturally based on our pathologic knowledge of the disease. Local excision, or fulguration, is curative only if the lesion is confined to the mucosa or submucosa and can be entirely eradicated. This, however, demands institution of early therapy which, in most cases, is impossible by the time the patient presents himself. The margin of safety is so small that except for the simple polypectomy this method is hazardous. Radium and irradiation, as well as fulguration, are now used mainly as palliative procedures in the inoperable cases, whether due to widespread involvement or to other physical disability.

For the next twenty-five years after the Miles operation practically supplanted all other operative procedures for cancer of the rectum, the patient was offered this with an abdominal colostomy, with no alternative. Many refused a permanent abdominal colostomy and elected local application of

radium or fulguration of the lesion as a palliative procedure. Many who accepted the abdominoperineal resection, with an abdominal colostomy, have sought further surgical aid and the transplantation of the abdominal colostomy to the perineal area. Babcock<sup>6</sup> has performed more than 50 of these operations. Several doctors are included in this latter group.

Success in ridding the patient of cancer does not necessarily mean success in leaving the patient a happy existence. Thus, in 1932, Babcock<sup>6</sup> offered a method of "procotostigmoidectomy" without abdominal colostomy, with preservation of the external anal sphincter muscle, applicable to the removal of all lesions below the level of the midsigmoid. In the past decade other surgeons, including Pratt<sup>7</sup>, Wangenstein<sup>8</sup>, Horsley<sup>9</sup>, Stone<sup>10</sup>, Fallis<sup>11</sup>, Dixon<sup>12</sup>, and Zinninger<sup>13</sup> have offered methods of preserving the sphincter musculature by abdominoperineal or sacral methods, or end-to-end anastomosis by aseptic or open methods. Horsley put the problem in these words: "Something more than mere existence should be included in the objectives of surgery—if the patient can be made more comfortable and life is made to seem more worthwhile after a procedure that offers about equal chances of cure of the cancer as other operations, it is obvious that this technique should be adopted."

The pathologic studies of the past decade which have modified the views of Miles as to the lateral and downward spread of rectal and sigmoid cancer have led to less radical procedures than the abdominoperineal resection. It still remains, however, the procedure of choice for the lesion in the distal 6 cm. of the rectum, but fortunately only 20 per cent of the growths occur in this area.

Operability has changed greatly in the past few decades. McFarland<sup>14</sup> at the Toronto General Hospital reported a series of cases from 1920-25 with 90 per cent being inoperable. In another group from 1930-40, the operability was 63 per cent instead of 10 per cent. Other surgeons have reported an operability of 80 to 90 per cent. In contradistinction, the operative mortal-

ity rate has progressively dropped until it now does not exceed 10 per cent, and is reported in a series by Bacon<sup>15</sup> as low as 5.5 per cent. The five-year survival rate following surgical extirpation ranges from 22 to 73 per cent, and averages 40 per cent. The ideal, of course, is a high operability rate, a low operative mortality and a high survival rate. These must be taken together, and comparisons made between different methods of surgical approach must include all three factors.

The introduction of chemotherapy, with the preoperative preparation of the patient with sulfasuxidine, the use of vitamins C and amino acids, as well as whole blood and blood plasma, have markedly reduced the danger of operation. Bacon<sup>15</sup> has a series of 49 consecutive cases of his modification of the "pull through" operation of Babcock with an operative mortality of only 2.4 per cent. It might be mentioned here that this method has the additional advantage of sphincter function and continence in 80 per cent of their cases; early wound healing and early return to work; and impotence which almost invariably follows the Miles operation is seen in less than one-third of the cases following this procedure.

For lesions of the sigmoid well above the rectosigmoid junction, and end-to-end anastomosis offers many advantages. But for cancer of the rectum, including the rectosigmoid junction, the technical difficulties involved and the possibility of compromising an adequate resection makes this procedure hazardous.

In summary, one must remember that cancer of the rectum is encountered frequently. It must always be considered and ruled out with every rectal complaint and examination. It is amenable to cure by early surgical extirpation, and the postoperative life of the patient does not necessarily have to be an unhappy existence.

EDGAR BOLING, M.D.

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## APPROXIMATELY 6,500,000 PERSONS IN U. S. HAVE STOMACH ULCERS

It is conservatively estimated that at least five per cent of the population or about 6,500,000 persons suffer from stomach ulcers, according to William W. Bolton, M. D., of the Bureau of Health Education of the American Medical Association.

Writing in *Hygeia*, Dr. Bolton describes the ulcer type of person as one who is thin, inclined to limited activity, nervous, rather short tempered and easily upset. He is never a robust eater and is choosy in his diet.

Stomach ulcers are known more properly by the term peptic ulcer, a designation including those found on the portion of the intestinal tract leading from the stomach and called the duodenum.

Describing the symptoms, Dr. Bolton says: "Pain time depends on the location of the ulcer. If it is in the stomach, pain usually develops from one-half to two hours after a meal. It is the signal that the stomach is empty . . . and is squeezing the ulcer again. If the ulcer is in the duodenum, which it is far more commonly, especially in men, the pain may not start for from two to four hours after a meal.

"Two eventualities which may prove of serious import, though rarely fatal, in ulcer cases are hemorrhage or perforation. In the former, bleeding occurs sometimes in alarming amounts when the ulcer chances to erode into a blood vessel in the wall of the stomach or duodenum. In the latter, a surgical emergency exists but prompt intervention insures recovery in practically all instances.

"Cancerous degeneration is a possibility, but it is not as frequent as might be expected. General opinion is that duodenal ulcers almost never degenerate into cancer, and stomach ulcers in not more than 10 per cent of cases."

The causes of ulcers are many. The author points out that "it's uncommon to find the same causes operating in two consecutive cases. Local factors may be responsible in some instances, such as the decrease in resistance of the sensitive tissues lining the stomach or an unexplained decrease in an adequate blood supply to the area. Some authorities are inclined to blame alterations in the acid content of the juice secreted by

the stomach. This opinion is supported by the fact that in many cases of peptic ulcer hyperacidity of the gastric fluid is present.

"Other investigators have found what appears to be a definite link between peptic ulcers and the presence of foci of infection in other, often far removed, areas of the body. Ulcers have been related to abnormal operation of the various glands of internal secretion."

Continuing, Dr. Bolton writes that "effective treatment is based on recognition that mild, soothing food with frequent feedings serves to keep the stomach partially filled and that neutralization of the excess acidity usually present is necessary.

"Recently a new treatment has brought excellent results. It consists of administration of concentrated protein preparations, either by mouth or through injection into a vein. Following the start of this treatment, ulcers disappeared as though by magic. Though final evaluation of this treatment must await further study, it appears to have significant possibilities."

## LACK OF HEART PAIN IN NEGROES DECEIVING IN DIAGNOSIS

Coronary thrombosis, one of the leading causes of death in this country, is as common among Negroes as it is among white people, according to William S. Hunter, M.D., of Louisville, Ky. However, since the Negro rarely has pain it is not usually diagnosed as heart disease before death.

Writing in the May 4 issue of *The Journal of the American Medical Association*, Dr. Hunter says that "it seems likely that between 2,800 and 4,600 Negroes in the United States are killed every year by myocardial infarction and that many more are disabled by the condition."

Dr. Hunter, who is from the Departments of Internal Medicine and Pathology, the University of Louisville Medical School, suggests that the absence of pain may be due to the fact that high blood pressure had been found to be much more common and much more severe among Negroes than among white people. This condition probably causes an enlargement of the secondary arteries through which the blood is detoured to the heart muscle. Thus pain is eliminated for it occurs only when some part of the heart muscle is deprived of its necessary blood supply.

Coronary thrombosis is usually associated with prolonged pain and with permanent damage to the heart during attacks. There is always shortness of breath and there may be some coughing because of water accumulating in the lungs as a result of the impaired circulation. Also present is a rapid and irregular pulse and a fall in blood pressure.

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### PRESIDENT'S REPORT TO AUXILIARY MEMBERS AT STATE CONVENTION IN MACON, 1946

On Tuesday evening I appeared before the House of Delegates of the Medical Association of Georgia and gave them a report of the work done by the Auxiliary the past two years. This report was a brief one compiled from the reports sent in by county presidents and district managers.

Yesterday detailed reports were given you by county presidents and district managers. Today, you have heard from the officers and chairmen of standing committees. To prevent any repetition, I shall confine this report to one of my own activities as your state president and my efforts to fulfill the obligation to you and to the Medical Association.

At the post-convention meeting held immediately following the 1944 convention, chairmen of standing committees and delegates to the American Medical and Southern Medical conventions were appointed. In June I had the pleasure of attending the convention of the American Medical Association in Chicago. In July, in accordance with the resolution adopted at the 1943 convention, the chairman of Health Education and the Public Relations and Visual Education chairmen met with the president and president-elect to formulate a cooperative plan of health education for the ensuing year. These plans with those of the state committee were compiled and presented as a complete unit.

In August, the Executive Board met in Atlanta at the Academy of Medicine with our Advisory Committee from the Medical Association of Georgia. At this time program plans were presented and approved. May I take this opportunity to thank each officer and chairman for enabling me to present to the Advisory Committee a complete plan for the year's work. Following this meeting, mimeographed copies of the program plans were sent to each county president and district manager, accompanied by a letter from the president. Copies were also sent to the officers of the A. M. A. and S. M. A. Stationery was printed and delivered to state chairmen, to officers and to district managers, together with directories of our Executive Board personnel. Copies of this directory were sent to

headquarters of the American Medical Association in Chicago, and to officers and chairmen of the Southern Medical and American Medical associations.

Articles for publication in the Medical Journal and the *Atlanta Constitution* were written for use when the press and publicity chairman called for them.

From December to February I worked full time in my husband's office and served as a nurse's aide on the week-ends and in the evening when needed, so Auxiliary work came second during this period. After Dr. Shanks notified me that there would be no convention in 1945, I again wrote letters to each county president and district manager and to each state chairman. In August plans were sent out with new directories of county presidents and district managers where these changes had been made. Since there were no changes in the program plan and everyone was so busy in war services, no Executive Board meeting was called.

Early in February I met with the Bibb County Auxiliary and plans for the convention were made. The program for the convention was compiled and sent to be published in the Medical Journal, with letters of invitation from Mrs. W. E. Mobley and myself to the convention. In March questionnaires were sent to district managers and county presidents. I have received reports from six districts out of nine, and from 16 county auxiliaries out of a total of 20 county auxiliaries which have paid dues. We have 17 members-at-large, and a total membership of 514.

During my two years in this office 620 personal letters have been written; 272 form letters and 65 cards sent out. I have served as a member of the State Nutrition Council, Georgia Citizens' Council and as a participant of the Social Hygiene Conferences. I have attended three district meetings, seven auxiliaries, four meetings of the Georgia Citizens' Council and two Social Hygiene Conferences.

You have had many presidents who have traveled more miles and visited more county and district meetings, but there has never been one who has stood up for so many miles! Traveling in wartime leaves much to be desired in comfort. Eleven trips were made to Atlanta by bus,



because bus traveling was much more convenient than the before-dawn schedule of the trains, and all but two of these were made by foot. It is now necessary for the state president to have strong arches, at least until cars are a little more plentiful.

It has been a pleasure to perform the duties of this office as best I could under the trying circumstances that we have experienced. It has been hard at times to concentrate on Auxiliary plans when our thoughts were on the seas and on foreign soil with our loved ones. The new friends made and old friendships renewed have made the effort worthwhile and all of these shall be added to our store of cherished memories.

May we continue to grow and serve the profession to which we are so closely allied.

Respectfully submitted,

EVELYN RANDOLPH, *President*  
(Mrs. W. T. Randolph)

The April meeting of the Randolph-Terrell Woman's Auxiliary to the Medical Association of Georgia met at the home of Mrs. J. C. Patterson, with nine members present, and two new members. Mrs. T. F. Harper presided. The minutes were read and approved. Delegates were nominated for the annual meeting to be held in Macon. They were: Mrs. W. W. Arnold, Mrs. S. P. Kenyon and Mrs. R. B. Martin. The following officers were elected:

Mrs. R. B. Martin, Cuthbert.....*President*  
Mrs. T. F. Harper, Coleman.....*Vice-President*  
Mrs. W. G. Elliott, Cuthbert.....*Secretary-Treasurer*

Mrs. Martin read the letter sent to county presidents from the Chatham County Woman's Auxiliary concerning the Wagner-Murray-Dingell bill. It was voted that all members bring a suggestion to the next meeting as to how we can assist the doctors in their program of organization. A delightful social hour was enjoyed.

#### CHAIRMEN OF STANDING COMMITTEES

1946-1947

PUBLIC RELATIONS—Mrs. Edgar H. Greene, 1442 W. Wesley Road, Atlanta.

VISUAL EDUCATION—Mrs. R. L. Neville, 314 E. 45th Street, Savannah.

LEGISLATION—Mrs. John Elliott, 210 E. Huntington Street, Savannah.

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DOCTORS' DAY—Mrs. Charles Cooper, 146 Beverly Place, Macon.

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STUDENT LOAN FUND—Mrs. J. Lon King, 223 Buford Place, Macon.

JANE TODD CRAWFORD MEMORIAL—Mrs. B. E. Collins, Cherokee Street, Waycross.

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BULLETIN—Mrs. D. H. Garrison, Clarksville.

REVISIONS—Mrs. Lee Howard, 625 E. 41th Street, Savannah.

ACHIEVEMENT AWARD—Mrs. L. W. Williams, 135 E. 45th Street, Savannah.

#### DOCTOR STATES NAVY MEN NOT LIKELY TO SPREAD FILARIASIS

*Parasite Is Transmitted Only By Mosquito In Which It Matures, Not By Human Contact*

There is no danger of filariasis, a mosquito borne disease, being spread in a community by the returning serviceman, according to Capt. L. T. Coggeshall (MC) U.S.N.R. A study of several thousand sailors and Marines reveals that their infection was extremely light; they were removed immediately from the area where the disease was prevalent and examination showed their blood to be free of parasites.

Writing in the May 4 issue of *The Journal of the American Medical Association*, Capt. Coggeshall, who was aided in his study by 12 Navy associates, says that filariasis was acquired by 10,431 Navy personnel in the South Pacific area, mostly in the Samoan group of islands. Of these 2,595 were observed over a 17 month period at Klamath Falls, Oregon.

Filariæ are threadlike worms which are transmitted to man by mosquito bites. Without the intermediary mosquito the disease cannot be spread. The adult worms live in the lymph glands while the larvae migrate into the blood stream where they are usually found only at night. During the waking hours of the patient it has been assumed that they retire to the lungs, kidneys and deep-lying tissues.

The filariæ may be present in the body without causing any symptoms. It is only when the worms block lymph channels that definite symptoms occur, such as inflammation of the lymph glands which causes fever and painful swelling of the affected parts.

The author enumerates some of the reasons why there is no need to fear the establishment of filariasis in the United States by returning servicemen. He cites another investigator who says that a "climate favorable for the development of the larvae in the mosquito requires a mean temperature of 80 F. and a humidity above 60 per cent. If this is true, only a relatively small area of the United States, those states bordering on the Gulf of Mexico, Georgia and South Carolina, is suitable. Filariasis was once prevalent in a part of that region as a result of the introduction of heavily infected slaves, yet it was unable to maintain itself and died out spontaneously. . . . There is no danger of spreading the disease by contact. Actually blood from an infected donor can be used for transfusion purposes without danger, as the larvae are noninfective for man unless they have partially matured in a mosquito and been introduced by biting. These and other reasons, such as better screening and mosquito control, would seem definitely to assure us that filariasis will not spread in this country and that the released serviceman cannot be a source of danger to his associates."

No specific treatment was employed because none of the men were ever very ill.

Elephantiasis, a complication of filariasis in which there is an enlargement of the infected parts, was observed in natives only after prolonged exposure. Although greatly feared by servicemen no cases have been found and because the men are no longer exposed, it is not expected that it will occur.

## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1008 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, Walnut 8911; residence, Jackson 7979.

### GEORGIA NURSES IN THE DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Appointment of nurses, physicians and dentists subsequent to January 3, 1946, will be made directly to the Department of Medicine and Surgery upon the recommendation of the chief director.

With the enactment of Public Law No. 293 and the demobilization of millions of veterans of World War II, the medical task of the Veterans Administration becomes a challenge and an opportunity.

It is a challenge to the country to provide the best medical care and treatment for war-torn veterans. It is an opportunity for qualified physicians, nurses and dentists to reap the finest in professional progress and experience while giving the highest caliber of service of which they are capable, to a deserving segment of humanity.

In Georgia nurses are being placed in the following three veterans' hospitals: Augusta, Atlanta and Thomasville. The Branch Office No. 5 is in Atlanta, and covers the territory of the Fourth Service Command.

The following information is subject to change as procedures for implementing Public Law No. 293 are determined. An integral part of the department is the nursing service under supervision of a director. Under this law, the administrator of veterans' affairs will establish regulations to replace the Civil Service rules which formerly governed VA professional personnel.

Through appointment, promotion and disciplinary boards to be set up by the administrator, the Veterans' Administration will have complete supervision of its own nurses, physicians and dentists, based upon their professional competence. Nurses, doctors and dentists appointed to the Department of Medicine and Surgery will not be Civil Service employees.

A new salary scale commensurate with training and experience has been established, as follows:

	<i>Pay Per Annum</i>
Assistant Directors .....	\$5,180-\$6,020

*Positions*—Supervisor, Branch Office: Consultant in Special Field of Nursing.

Senior Grade ..... \$4,300-\$5,180

*Positions*—Chief Nurse, large hospital; Assistant Supervisor, Branch Office.

Full Grade ..... \$3,640-\$4,300

*Positions*—Assistant Chief Nurse, large hospital; Chief Nurse, small hospital; Educational Director.

Associate Grade ..... \$2,980-\$3,640

*Positions*—Instructor; Head Nurse.

Junior Grade ..... \$2,320-\$2,980

*Position*—Staff Nurse.

Pay increases with length of service within these limits. Nurses appointed while on terminal leave from the armed forces will receive service leave pay and their VA salaries while they are members of both services.

Promotions to higher grades will be based upon performance and interest in nursing and nursing education.

Nurses are not required to live on station, and there are no accommodations there for married nurses wishing to live with their families. When nurses live off-station, a deduction for one meal a day is made from the base salary. This varies from a minimum of \$90 a year where cafeteria service is provided to \$109 a year where meal is served at table. A minimum deduction of \$420 per year is made from base salary when nurse lives on-station. On-station quarters are not always available, however.

*Retirement*: Although not Civil Service employees, nurses, physicians and dentists in the Department of Medicine and Surgery will be subject to the regulations of, and receive the benefits under the Civil Service Retirement Act of May, 22, 1920, as amended. Five per cent deductions for retirement are made from all base salaries. Retirement is based on age or disability and aggregate service of at least five years. Honorable military service not forming basis for pension is counted for retirement in the same manner as Civil Service. Preference will be given to qualified veterans.

*Qualifications*: Basic Requirements: 1. Citi-



zenship in the U. S.; 2. Successful completion of a course of nursing in a recognized school of nursing approved by the administrator; 3. Registration as a graduate nurse in one of the states or territories of the U. S. or in the District of Columbia; 4. Compliance with physical requirements of the department; 5. Professional experience as required.

*Applications:* During the present period of transition, Civil Service forms may be used when VA forms are not available.

*Information:* For further information consult the manager of the nearest VA hospital, regional office or center, or write to: Acting Chief Medical Director, Veterans' Administration, Washington 25, D. C.

#### MEDICAL ASSOCIATION OF GEORGIA

##### *Financial Statement of Cash Assets*

May 1, 1944, to April 30, 1945

##### RECEIPTS

May 1, 1944:

Cash in Fulton National Bank subject to check .....	\$19,350.23
Six \$1,000 U. S. Government Bonds, with accrued interest, Series D, 337880-85, June 1939, 10-year bonds .....	5,100.00
Four \$1,000 U. S. Government Bonds, with accrued interest, Series D, 843380-83, January 1940, 10-year bonds .....	3,360.00
One \$10,000 U. S. Government Bond, Series F, X183923, June 1944, 12-year bond .....	7,400.00
Fulton National Bank, with interest .....	1,356.91
Citizens & Southern National Bank, with interest .....	5,518.34
First National Bank, with interest .....	5,476.09
Standard Federal Savings & Loan Association, with interest .....	5,669.83
Receipts from operating (May 1, 1944, to April 30, 1945) .....	22,668.57
	\$75,899.97

##### DISBURSEMENTS

April 30, 1945:

Disbursements itemized .....	\$27,373.58
Cash in bank subject to check .....	14,645.22
Six \$1,000 U. S. Government Bonds .....	5,100.00
Four \$1,000 U. S. Government Bonds .....	\$ 3,360.00
One \$10,000 U. S. Government Bond .....	7,400.00
Fulton National Bank .....	1,356.91
Citizens & Southern National Bank .....	5,518.34
First National Bank .....	5,476.09
Standard Federal Savings & Loan Association .....	5,669.83
	\$75,899.97

#### MEDICAL ASSOCIATION OF GEORGIA

##### *Receipts and Disbursements*

##### RECEIPTS

May 1, 1944, to April 30, 1945

Cash on hand subject to check .....	\$19,350.23
Receipts (other than accrued interest) .....	22,668.57
	\$42,018.80

##### DISBURSEMENTS

Disbursements itemized .....	\$27,373.58
Cash in bank subject to check .....	14,645.22
	\$42,018.80

#### THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

##### *Receipts and Disbursements*

May 1, 1944, to April 30, 1945

##### RECEIPTS

Advertising .....	\$10,322.84
Membership subscriptions .....	4,116.50
Regular subscriptions .....	105.38
	\$14,544.72

##### DISBURSEMENTS

Printing and mailing .....	\$ 4,915.12
Salaries .....	3,052.00
Postage .....	222.50
Engraving .....	234.91
Rent .....	317.50
Extra secretarial work .....	270.00
Commission on advertising .....	138.36
News clippings .....	55.00
Copyright .....	24.00
Addressograph .....	31.12
Gain .....	5,284.21
	\$14,554.72

#### MEDICAL ASSOCIATION OF GEORGIA

##### *Receipts and Disbursements*

May 1, 1944, to April 30, 1945

##### SOURCES OF INCOME

Dues .....	\$ 9,603.85
Advertising .....	10,322.84
Exhibits .....	2,616.50
One \$10,000 U. S. Government Bond .....	7,400.00
Interest .....	288.89
Subscriptions .....	105.38
Public Relations Bureau .....	20.00
	\$30,357.46

##### DISBURSEMENTS

Itemized expenses .....	\$27,373.58
Gain .....	2,983.88
	\$30,357.46

May 1, 1944:

Cash and cash assets .....	\$45,542.51
Gain in cash and cash assets .....	2,983.88
April 30, 1945:	
Cash and cash assets .....	\$48,526.39

##### INCOME

May 1, 1944, to April 30, 1945

Date	Deposited in Bank	Source	Amount	
May 24, 1944		Dues .....	\$ 258.85	
		Ads .....	624.64	
		Exhibits .....	42.50	
		Subscription .....	3.00	\$ 928.99
June 6, 1944		Dues .....	301.00	
		Ads .....	12.00	
		Subscription .....	2.50	
		Exhibits .....	859.00	1,174.50
June 28, 1944		Dues .....	161.00	
		Ads .....	740.38	
		Exhibit .....	100.00	1,001.38
July 19, 1944		Dues .....	42.00	
		Ads .....	725.13	
		Subscriptions .....	6.88	774.01
Aug. 18, 1944		Dues .....	105.00	
		Ads .....	636.95	
		Subscriptions .....	6.00	
		Public Relations Bureau .....	20.00	767.95
Sept. 16, 1944		Dues .....	133.00	
		Ads .....	1,081.74	1,214.74
Oct. 11, 1944		Dues .....	87.50	
		Ads .....	121.47	
		Subscriptions .....	16.50	
		Exhibits .....	235.00	460.47

Oct. 27, 1944	Dues	35.00		4285—Mrs. J. P. Norris	
	Ads	714.09		Transportation, expenses and work at	
	Subscriptions	12.50		Registration Desk, Savannah Session,	
	Exhibits	815.00	1,576.59	May 9-12, 1944	45.95
Nov. 24, 1944	Dues	101.50		4286—Franklin Printing Corporation	
	Ads	739.30		Printing and mailing 2400 copies of	
	Subscriptions	15.00		April 1944 issue of The Journal	455.53
	Exhibits	405.00	1,260.80	4287—Artcraft Engraving Company	
Dec. 19, 1944	Dues	123.50		Cuts from photos of officers, work on	
	Ads	1,645.76		electros, and cuts for illustrations for	
	Subscriptions	17.50		scientific papers	65.14
	Exhibits	160.00	1,946.76	4288—Atlanta Linen Service	
Jan. 12, 1945	Dues	903.00		Linen Service for April and May 1944	2.50
	Ads	32.15		4289—Southern Bell Telephone & Telegraph	
	Subscriptions	8.00	943.15	Company	
Jan. 26, 1945	Dues	1,575.00		Account to April 21, 1944	7.68
	Ads	576.29		Check returned—Blackman Sanato-	
	Subscriptions	5.50	2,156.79	rium for endorsement, May 2, 1944	13.50
Feb. 9, 1945	Dues	1,841.00		4290—Bettercourt Sign Company	
	Ads	155.36	1,996.36	Painting 37 signs for the Ninety-Fifth	
Feb. 23, 1945	Dues	686.00		Annual Session, Savannah, May 9,	
	Ads	845.13		1944	57.00
	Subscription	3.00	1,534.13	4291—Margie Hartis	
March 9, 1945	Dues	674.00		Looking after list of rooms to rent, typ-	
	Ads	9.00		ing, help at registration desk, selling	
	Subscriptions	6.00	689.00	alumni dinner tickets and banquet	
March 23, 1945	Dues	336.00		tickets (for Margie Hartis and Fae	
	Ads	858.20		McElveen)	25.00
	Subscription	3.00	1,197.20	4292—D. B. Graham	
March 30, 1945	Dues	1,316.00		Six alternating watchmen for technical	
	Ads	20.80	1,336.80	exhibit at annual session, May 9-12,	
April 20, 1945	Dues	826.00		1944	97.00
	Ads	52.02	878.52	4293—Cash	
April 6, 1945	Dues	98.00		Cab service, electric bulbs, phone calls,	
	Ads	732.43	830.43	work on technical exhibit, janitor	
				service and other work, Savannah ses-	
				sion, May 9-12, 1944	88.50
			\$22,668.57	4294—J. D. Grant	
				Expenses to and from Savannah for	
				work on the technical exhibit during	
				annual session, May 9-12, 1944	69.07
				4295—Hotel DeSoto, Savannah	
				Expenses of H. L. Rowe, Executive Sec-	
				retary, during the Ninety-Fifth An-	
				nuual Session	47.96
				4296—L. F. Livingston, Postmaster	
				Deposit for postage to mail The Journal	50.00
				4297—Franklin Printing Corporation	
				Association programs for the Ninety-	
				Fifth Annual Session held at Hotel	
				DeSoto, Savannah, May 9-12; pro-	
				grams for the Woman's Auxiliary;	
				registration cards	180.00
				4298—Logan Clarke Insurance Company, Inc.	
				Premium on surety bond for Secretary-	
				Treasurer for one year, F.B. 98062-A	5.00
				4299—S. Elliott Wilson, M. D.	
				Expense for music at Memorial exer-	
				cises held at Savannah, May 11, 1944	
				(during annual session)	5.00
				4300—L. F. Livingston, Postmaster	
				Postage	30.00
				4301—Southern Bell Telephone & Telegraph	
				Company	
				Account to May 21, 1944	8.83
				4302—Edgar D. Shanks, M. D.	
				Salary for Secretary-Treasurer May	
				1944, less withholding tax	226.00
				4303—H. L. Rowe	
				Salary for Executive Secretary May	
				1944, less withholding tax	196.80
				4304—Member	
				Pension from Benevolent Fund	30.00
				4305—Wm. A. Mulherin, M. D.	
				Payment on expenses of delegate to at-	
				tend annual session of the American	
				Medical Association, Chicago, June	
				12-16, 1944	150.00

## MEDICAL ASSOCIATION OF GEORGIA

## Disbursements Itemized

May 1, 1944, to April 30, 1945

Check Number	Name	Amount
4271—Miss Annie Jacks		
	Commission on advertising orders	\$107.16
4273—Woman's Auxiliary to the Georgia		
	Medical Society Commission on adver-	
	tising orders for April 1944 Journal, for	
	Savannah firms	80.63
4274—Western Union Telegraph Company		
	Telegraph account for April 1944	3.10
4275—Addressograph-Multigraph Corp.		
	Ribbon, ribbon support and work	4.05
4276—Herff-Jones Company		
	Gold Key for President Selman	10.02
4277—St. Louis Button Company		
	600 Badges for the Savannah Session	
	May 9-12, 1944	60.69
4278—Edgar D. Shanks, M. D.		
	Salary for Secretary-Treasurer, April	
	1944, less withholding tax	226.00
4279—H. L. Rowe		
	Salary for Executive Secretary, April	
	1944, less withholding tax	196.80
4280—Member		
	Pension from Benevolent Fund	30.00
4281—J. F. Thompson Engraving Company		
	Printing in reference to Savannah Ses-	
	sion and Senate bill 1161	42.00
4282—Mrs. G. R. Sims		
	Extra secretarial work, May 1, 1943 to	
	April 30, 1944	240.00
4283—Edgar D. Shanks, M. D.		
	Travel and other necessary expenses for	
	the Association	283.00
4284—H. L. Rowe		
	Cab and street car fares	12.00



4306—Olin H. Weaver, M. D. Payment on expenses of delegate to attend annual session of the American Medical Association, Chicago, June 12-16, 1944 .....	150.00	4329—Southern Press Clipping Bureau Press clippings for June and July 1944 .....	10.00
4307—Allen H. Bunce, M. D. Payment on expenses of delegate to attend annual session of the American Medical Association, Chicago, June 12-16, 1944 .....	150.00	4330—Western Union Telegraph Company Account to June 16, 1944 .....	4.09
4308—Edgar D. Shanks, M. D. Payment on expenses of Secretary- Treasurer to attend annual session of the American Medical Association, Chicago, June 12-16, 1944 .....	150.00	4331—Ivan Allen-Marshall Company Letter folders, paste and pencils .....	5.85
4309—Franklin Printing Corporation Printing and mailing 2350 copies of the May 1944 issue of The Journal .....	389.49	4332—Grover Middlebrooks, Attorney Retainer fee for attorney from July 1, 1944 to December 31, 1944 .....	500.00
4310—Franklin Printing Corporation Binding 11 volumes of the 1943 issues of The Journal .....	29.50	4333—Addressograph-Multigraph Corp. Service on addressograph and supplies .....	10.29
4311—Ivan Allen-Marshall Company Typewriter paper .....	4.80	4334—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, July 1944, less withholding tax .....	226.00
4312—Southern Press Clipping Bureau News clippings for April and May 1944 .....	10.00	4335—H. L. Rowe, Salary for Executive Secretary, July 1944, less withholding tax .....	196.80
4313—Artacraft Engraving Company Cut for Auxiliary, and changes on plates for advertising .....	10.36	4336—Member Pension from Benevolent Fund .....	30.00
4314—L. F. Livingston, Postmaster Postage .....	30.00	4337—Atlanta Linen Service Linen account for August and Septem- ber 1944 .....	2.50
4315—Federal Reserve Bank, Atlanta One \$10,000.00 Series F U. S. Govern- ment bond to mature in 12 years .....	7,400.00	4338—Southern Bell Telephone & Telegraph Company Account to July 21, 1944 .....	6.90
4316—Miss Winifred H. McLean Stenographic report of the Savannah session, May 9-12, 1944, of general meetings, House of Delegates and minutes of Council .....	250.00	4339—L. F. Livingston, Postmaster Postage .....	30.00
4317—Associated Mutuals Marine insurance for one year, to June 21, 1945, for \$3,400 on picture ma- chines, loud speakers, screens, etc., for each Councilor to be used in the promotion of health programs .....	57.80	4340—Franklin Printing Corporation Printing and mailing 2350 copies of the July 1944 issue of The Journal .....	383.55
4318—Franklin Printing Corporation Reprints of Memorial Address by Wm. R. Dancy .....	18.00	4341—Artacraft Engraving Company Mounts for advertising plates and il- lustrations .....	15.60
4319—Member Pension from Benevolent Fund .....	30.00	4342—Grover Middlebrooks, Attorney Expenses to and from Eastman in suit of Mrs. Joe V. Keen vs. Dr. Warren A. Coleman .....	21.00
4320—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, June 1944, less withholding tax .....	226.00	4343—Register of Copyrights Deposit to pay copyright fees of The Journal .....	24.00
4321—H. L. Rowe Salary for Executive Secretary, June 1944, less withholding tax .....	196.80	4344—Grover Middlebrooks, Attorney Stenographic copy of trial of suit of Mrs. Joe G. Keen vs. Dr. W. A. Cole- man, Eastman .....	21.30
4322—Collector of Internal Revenue, Atlanta U. S. Government taxes withheld for the quarter ending June 30, 1944, from salaries of: H. L. Rowe .....	\$69.60	4345—Insurance Economics Society of America 3000 copies of Social Security Snow- ball .....	9.00
Edgar D. Shanks, M. D. ....	72.00	4346—Miss Annie Jacks Commission of advertising orders .....	26.70
4323—J. L. Campbell, M. D., Chairman Cancer Commission, Expense for educational purposes .....	150.00	4347—Member Pension from Benevolent Fund .....	30.00
4324—Atlanta Linen Service Linen account for June and July .....	2.50	4348—Searcy & Company Premium on fire insurance on material for scientific exhibit .....	10.00
4325—Southern Bell Telephone & Telegraph Company Account to June 21, 1944 .....	6.90	4349—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, Au- gust 1944, less withholding tax .....	226.00
4326—L. F. Livingston, Postmaster Postage .....	30.00	4350—Southern Bell Telephone & Telegraph Company Account to Aug. 21, 1944 .....	9.03
Check returned Aurex Jacksonville Company by G. H. Hall, July 3, 1944 .....	9.00	4351—H. L. Rowe Salary for Executive Secretary, August 1944, less withholding tax .....	196.80
4327—Artacraft Engraving Company Cuts for illustrations and work on plates for advertisers .....	19.47	4352—Associated Mutuals Renewal premium on \$2000 fire insur- ance policy on office furniture and fix- tures .....	3.16
4328—Franklin Printing Corporation Printing and mailing 2350 copies of the June 1944 issue of The Journal .....	369.75	4353—Atlanta Linen Service Linen service October and January 1944 .....	2.50
		4354—Franklin Printing Corporation Printing and mailing 2350 copies of the August issue of The Journal .....	364.24
		4355—L. F. Livingston, Postmaster Postage .....	30.00

4356—Southern Press Clipping Bureau News clippings for August and September 1944 .....	10.00	4384—Artercraft Engraving Company Cuts made for October issue of The Journal .....	29.05
4357—A. B. Dick Company Semi-annual service on mimeograph machine .....	9.00	4385—Carithers-Wallace-Courtenay, Inc. For office supplies .....	4.35
4358—Victor Animatograph Corporation Repairs for picture machines .....	7.03	4386—Dixie Seal & Stamp Company For making two rubber stamps .....	1.55
4359—Western Union Telegraph Company Account for September, 1944 .....	2.25	4387—Franklin Printing Corporation Printing and mailing 2350 copies of the October 1944 issue of The Journal .....	383.55
4360—Ivan Allen-Marshall Company One double entry ledger .....	1.50	4388—Western Union Telegraph Company October 1944 account .....	0.96
4361—Addressograph Sales Agency Addressograph supplies .....	2.75	4389—W. T. Smith Overhauling of typewriter .....	8.00
4362—Collector of Internal Revenue, Atlanta Income tax withheld from salaries for July, Augusta and September 1944 for: Edgar D. Shanks, M. D. .... \$72.00 H. L. Rowe .....	141.60	4390—J. B. Richards Printing Company 2000 membership cards for 1945 .....	18.95
4363—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, September 1944, less withholding tax .....	226.00	4391—J. D. Grant Storage on material for scientific exhibit for Medical Association of Georgia, June 1943 to June 1944 .....	25.00
4364—H. L. Rowe Salary for Executive Secretary, September 1944, less withholding tax .....	196.80	4392—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, November 1944, less withholding tax .....	226.00
4365—Member Pension from Benevolent Fund .....	30.00	4393—Viola Berry Salary for Executive Secretary, November 1944, less withholding tax .....	200.00
4366—L. F. Livingston, Postmaster Postage .....	30.00	4394—Member Pension from Benevolent Fund .....	30.00
4367—S. H. Bennett Drawings of Macon Auditorium plan .....	25.40	4395—Pig'n Whistle Sandwich Shops, Inc. Expenses luncheon for meeting of Council Nov. 29, 1944 .....	61.15
4368—Viola Berry Salary for Executive Secretary, Sept. 15, 1944 through Sept. 30, 1944 .....	80.60	4396—Southern Bell Telephone & Telegraph Company Account to Nov. 21, 1944 .....	10.11
4369—L. F. Livingston, Postmaster Deposit to cover cost of mailing The Journal .....	50.00	4397—Atlanta Linen Service Linen service November and December 1944 .....	2.50
4370—Southern Bell Telephone & Telegraph Company Account to Sept. 21, 1944 .....	9.03	4398—Artercraft Engraving Company Two mounts for November 1944 Journal .....	2.00
4371—Artercraft Engraving Company Mounts for advertising plates and illustrations for September 1944 .....	3.75	4399—Franklin Printing Company Printing and mailing 2350 copies of the November 1944 Journal .....	383.55
4372—Franklin Printing Corporation Printing and mailing 2350 copies of the September issue of The Journal .....	415.50	4400—Addressograph Sales Agency Quarterly inspection and servicing machines .....	7.40
4373—Eddie Thompson For janitor service May 1, 1944 through Oct. 31, 1944 .....	26.00	4401—L. F. Livingston, Postmaster Postage .....	30.00
4374—Grover Middlebrooks, Attorney Charges of court reporter for taking deposition of Dr. Calhoun McDougall in the case of John D. Harrison vs. Dr. Rhea W. Richardson .....	7.00	4402—Southern Press Clipping Bureau Clippings furnished during October and November 1944 .....	10.00
4375—Miss Annie Jacks Commission on advertising, September 1944 .....	4.50	4403—Dr. Cleveland Thompson Honorarium for President 1944-1945 .....	300.00
4376—L. F. Livingston, Postmaster Postage .....	30.00	4404—Dr. W. A. Selman Expenses 1944 for Committee on Procurement and Assignment of Physicians .....	200.00
4377—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, October 1944, less withholding tax .....	226.00	4405—Dr. J. B. Fitts Expenses 1944 for Committee on Procurement and Assignment of Physicians .....	200.00
4378—Viola Berry Salary for Executive Secretary, October 1944, less withholding tax .....	161.20	4406—Mrs. G. R. Sims Extra secretarial work May 1944 through December 1944 .....	200.00
4379—Member Pension from Benevolent Fund .....	30.00	4407—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, December 1944, less withholding tax .....	226.00
4380—Southern Bell Telephone & Telegraph Company Account to Oct. 21, 1944 .....	9.71	4408—Viola Berry Salary for Executive Secretary, December 1944, less withholding tax .....	186.80
4381—Viola Berry For office supplies .....	15.39	4409—Member Pension from Benevolent Fund .....	30.00
4382—Grover Middlebrooks, Attorney Fees re: John D. Harrison vs. Dr. Rhea W. Richardson .....	52.60	4410—Collector of Internal Revenue, Atlanta Income tax withheld from salaries, October, November, and December 1944, for account of: Edgar D. Shanks, M. D. .... \$72.00 Viola Berry .....	143.40
4383—L. F. Livingston, Postmaster For postage due .....	20.00		



4411—Remington Rand, Inc. One Remington Electric Portable Adding Machine .....	196.10	session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	100.00
4412—L. F. Livingston, Postmaster Postage .....	30.00	4439—Poloris Company, Inc. Refund for exhibit space No. 32, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	85.00
4413—Grover Middlebrooks, Attorney Retainer fee Jan. 1, 1945 to June 30, 1945 .....	500.00	4440—Ayerst, McKenna & Harrison, Ltd. Refund for exhibit space No. 30, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	85.00
4414—Southern Bell Telephone & Telegraph Company Account to Dec. 21, 1944 .....	10.11	4441—The Borden Company Refund for exhibit space No. 17, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	100.00
4415—Franklin Printing & Manufacturing Co. Printing and mailing 2400 copies of the December 1944 Journal .....	\$437.16	4442—Eli Lilly and Company Refund for exhibit space No. 13, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	100.00
2400 dues notice cards .....	11.50	4443—Ortho Products, Inc. Refund for exhibit space No. 11, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	80.00
4416—J. F. Thompson Engraving Company 2000 postcards and printing .....	\$24.50	4444—Pet Milk Sales Corporation Refund for exhibit space No. 26, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	100.00
5000 forms for mailing membership cards .....	12.50	4445—E. R. Squibb & Sons Refund for exhibit space No. 29, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	85.00
5000 envelopes .....	18.75	4446—Sharp & Dohme, Inc. Refund for exhibit space No. 15, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	100.00
4417—A. B. Dick Company Mimeograph stencil sheets .....	3.15	4447—Frederick Stearns & Company Refund for part payment of exhibit space No. 3, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	30.00
4418—Artaft Engraving Company One cut for The Journal .....	4.04	4448—White Laboratories, Inc. Refund for exhibit space No. 31, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	85.00
4419—Carithers-Wallace-Courtenay, Inc. Office supplies .....	7.65	4449—Otis E. Glidden & Company Refund for exhibit space No. 4, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	60.00
4420—The Ansley Hotel Expense for Committee on Public Policy and Legislation .....	2.50	4450—Lederle Laboratories, Inc. Refund for exhibit space No. 22-A, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	60.00
4421—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, January 1945, less withholding tax .....	232.40		
4422—Viola Berry Salary for Executive Secretary, January 1945, less withholding tax .....	192.00		
4423—Member Pension from Benevolent Fund .....	30.00		
4424—L. F. Livingston, Postmaster Postage .....	40.00		
4425—Western Union Telegraph Company Telegrams .....	1.21		
4426—Addressograph Sales Agency Addressograph plates and ribbon .....	1.88		
4427—L. F. Livingston, Postmaster Deposit to cover mailings of The Journal .....	50.00		
4428—Southern Bell Telephone & Telegraph Company Service to Jan. 21, 1945 .....	12.34		
4429—Atlanta Linen Service Linen service January and February 1945 .....	2.50		
4430—Southern Press Clipping Bureau Clippings furnished during December 1944 and January 1945 .....	10.00		
4431—Carithers-Wallace-Courtenay, Inc. Office supplies .....	8.90		
4432—Artaft Engraving Company Four cuts and one mount for The Journal .....	10.73		
4433—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of the January 1945 Journal .....	393.36		
4434—The National Library Binding Company Six Vols. 12" Pamphlets bound .....	3.90		
Twelve Vols. 12" Journals bound .....	27.60		
4435—The Ansley Hotel Expenses for Committee on Public Policy and Legislation .....	12.12		
4436—Addressograph Sales Agency Inspection of Addressograph machines .....	4.75		
4437—Burroughs Wellcome & Company, Inc. Refund for exhibit space No. 23, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington .....	100.00		
4438—Mead Johnson & Company Refund for exhibit space No. 18, annual			

4451—The Mennen Company Refund for exhibit space No. 12-A, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington	50.00	4472—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of the March 1945 Journal	399.85
4452—M & R Dietetic Laboratories, Inc. Refund for exhibit space No. 12-A, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington	50.00	4473—Southern Bell Telephone & Telegraph Company Service to March 21, 1945	9.25
4453—Schering Corporation Refund for exhibit space No. 25, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington	100.00	4474—Artercraft Engraving Company Cuts and mounts for The Journal	23.59
4454—Winthrop Chemical Company, Inc. Refund for exhibit space No. 36, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington	85.00	4475—Atlanta Linen Service Linen service March and April 1945	2.50
4455—The Doho Chemical Corporation Refund for exhibit space No. 25-A, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington	100.00	4476—Kenneth McCullough, M. D., Sec.-Treas. Ware County Medical Society. Refund for annual dues for Dr. L. L. Chastain, Waycross	7.00
4456—Ernst Bischoff Company, Inc. Refund for exhibit space No. 2, annual session of the Medical Association of Georgia, Macon, May 8-11, 1945. Meeting cancelled by Office of Defense Transportation, Washington	60.00	4477—L. F. Livingston, Postmaster Postage	45.00
4457—L. F. Livingston, Postmaster Postage	40.00	4478—Eddie Thompson Janitor service Nov. 1, 1944 to April 30, 1945	29.00
4458—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, February 1945, less withholding tax	232.40	4479—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, April 1945, less withholding tax	232.40
4459—Viola Berry Salary for Executive Secretary, February 1945, less withholding tax	192.00	4480—Viola Berry Salary for Executive Secretary, April 1945, less withholding tax \$192.00 Incidental expenses, car fare, etc.	15.00 207.00
4460—Member Pension from Benevolent Fund	30.00	4481—Member Pension from Benevolent Fund	30.00
4461—Fulton County Medical Society Gift to library of the Fulton County Medical Society, period Feb. 23, 1945 to May 23, 1946	625.00	4482—Mrs. G. R. Sims Extra secretarial work January 1945 to April 1945 Exchange on non-par checks	100.00 11.83
4462—Southern Bell Telephone & Telegraph Company Service to Feb. 21, 1945	25.96	Total	\$27,373.58
4463—Western Union Telegraph Company Telegrams	2.06	MEDICAL ASSOCIATION OF GEORGIA <i>Financial Statement of Cash Assets</i> May 1, 1945, to April 30, 1946	
4464—Southern Press Clipping Bureau Clippings furnished during February 1945	5.00		
4465—Artercraft Engraving Company Cuts for The Journal	51.18	RECEIPTS	
4466—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of the February Journal	421.59	May 1, 1945:-	
4467—L. F. Livingston, Postmaster Postage	30.00	Cash in Fulton National Bank subject to check	
4468—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, March 1945, less withholding tax	232.40	Six \$1,000 U. S. Government Bonds, with accrued interest, Series D, 337880-85, June 1939, 10-year bonds	
4469—Viola Berry Salary for Executive Secretary, March 1945, less withholding tax	192.00	Four \$1,000 U. S. Government Bonds, with accrued interest, Series D, 843480-83, January 1940, 10-year bonds	
4470—Member Pension from Benevolent Fund	30.00	One \$10,000 U. S. Government Bond, with accrued interest, Series F, X183923, June 1944, 12-year bond	
4471—Collector of Internal Revenue, Atlanta Income tax withheld from salaries for January, February and March 1945, for account of: Edgar D. Shanks, M. D.	\$52.80	One \$5,000 U. S. Government Bond, Series G, V562461, July 1945, 12-year bond	
Viola Berry	84.00 136.80	One \$10,000 U. S. Government Bond, Series G, X507692, July 1945, 12-year bond	
		Standard Federal Savings & Loan Association, with interest	
		Receipts from operating (May 1, 1945 to April 30, 1946)	
		DISBURSEMENTS	
		April 30, 1945:	
		Disbursements itemized	
		Cash in bank subject to check	
		Six \$1,000 U. S. Government bonds	
		Four \$1,000 U. S. Government Bonds	
		One \$10,000 U. S. Government Bond	
		One \$5,000 U. S. Government Bond	
		One \$10,000 U. S. Government Bond	
		Standard Federal Savings & Loan Association	



## MEDICAL ASSOCIATION OF GEORGIA

*Receipts and Disbursements*

## RECEIPTS

May 1, 1945, to April 30, 1946

Cash on hand subject to check	\$14,645.22	
Receipts (other than accrued interest)	41,527.35	\$56,172.57

## DISBURSEMENTS

Disbursements itemized	\$32,821.28	
Cash in bank subject to check	23,351.29	\$56,172.57

## THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

*Receipts and Disbursements*

May 1, 1945, to April 30, 1946

## RECEIPTS

Advertising	\$13,411.76	
Membership subscriptions	5,072.36	
Regular subscriptions	58.40	\$18,542.52

## DISBURSEMENTS

Printing and mailing	\$5,996.54	
Salaries	2,820.00	
Postage	365.00	
Envelopes	306.98	
Engraving	165.48	
Extra secretarial work	275.00	
Commission on advertising	121.23	
News clippings	50.00	
Copyright	24.00	
Addressograph	37.27	
Gain	8,381.02	\$18,542.52

## MEDICAL ASSOCIATION OF GEORGIA

*Receipts and Disbursements*

May 1, 1945, to April 30, 1946

## SOURCES OF INCOME

Dues	\$11,837.50	
Advertising	13,411.76	
Exhibits	3,619.10	
One \$5,000 U. S. Government Bond	4,940.00	
One \$10,000 U. S. Government Bond	9,880.00	
Interest	670.59	
Subscriptions	58.40	\$44,317.35

## DISBURSEMENTS

Itemized expenses	\$32,821.28	
Gain	11,596.07	\$44,317.35

May 1, 1945:

Cash and cash assets \$48,526.39

Gain in cash and cash assets 11,596.07

April 30, 1946:

Cash and cash assets (April 30, 1946) 60,122.46

## INCOME

May 1, 1945, to April 30, 1946

Date	Deposited in Bank	Source	Amount	
May 19, 1945	Dues		\$252.50	
	Ads		898.17	\$ 1,150.67
June 16, 1945	Dues		272.00	
	Ads		786.69	
	Subscriptions		8.70	1,067.39
June 30, 1945	Dues		140.00	
	Ads		232.89	
	Subscription		.30	373.19
July 2, 1945	Ads		20.90	
	Savings accounts		12,413.09	12,433.99

July 14, 1945	Dues	7.00	
	Ads	683.93	690.93
Aug. 18, 1945	Dues	56.00	
	Ads	862.18	
	Subscriptions	1.00	919.18
Sept. 15, 1945	Dues	87.50	
	Ads	1,007.29	
	Subscription	4.00	1,098.79
Oct. 6, 1945	Dues	28.00	
	Ads	569.81	
	Subscriptions	4.00	601.81
Oct. 13, 1945	Ads	827.34	
	Subscriptions	3.30	830.64
Oct. 27, 1945	Ads	95.74	
	Subscription	.30	
	Exhibits	1,283.80	1,379.84
Nov. 3, 1945	Dues	21.00	
	Ads	112.33	
	Subscription	2.50	
	Exhibits	916.30	1,052.13
Nov. 17, 1945	Dues	192.50	
	Ads	781.03	
	Subscription	2.50	
	Exhibits	352.80	1,328.83
Dec. 8, 1945	Dues	119.00	
	Ads	341.78	
	Subscriptions	5.50	
	Exhibits	225.40	691.68
Dec. 15, 1945	Dues	91.00	
	Ads	723.24	
	Exhibit	85.00	899.24
Dec. 19, 1945	Dues	7.00	
	Ads	1,513.57	
	Subscription	2.50	1,523.07
Jan. 12, 1946	Dues	637.00	
	Ads	195.40	
	Interest on U. S. Bonds	187.50	
	Subscriptions	5.80	1,025.70
Jan. 18, 1946	Dues	567.00	
	Ads	254.65	821.65
Feb. 2, 1946	Dues	1,330.00	
	Ads	587.01	
	Exhibits	158.80	2,075.81
Feb. 21, 1946	Dues	847.00	
	Ads	918.98	
	Subscriptions	7.50	
	Exhibits	196.00	1,969.48
March 9, 1946	Dues	1,379.00	
	Ads	55.40	1,434.40
March 16, 1946	Dues	3,759.00	
	Ads	151.94	
	Subscriptions	6.00	
	Exhibit	85.00	4,001.94
March 30, 1946	Dues	483.00	
	Ads	829.10	
	Subscriptions	3.50	1,315.60
April 13, 1946	Dues	581.00	
	Ads	193.40	
	Subscription	1.00	775.40
April 20, 1946	Dues	616.00	
	Ads	728.75	
	Exhibit	60.00	1,404.75
April 30, 1946	Dues	365.00	
	Ads	40.24	
	Exhibits	256.00	661.24
			\$41,527.35

## MEDICAL ASSOCIATION OF GEORGIA

*Disbursements Itemized*

May 1, 1945, to April 30, 1946

Check Number	Name	Amount
4483	Dr. Spencer A. Kirkland	
	Expense in connection with Committee on Public Policy and Legislation 1945	75.00

4484—Dr. J. L. Campbell Expense Committee on Public Policy and Legislation 1945 .....	50.00	4512—Grover Middlebrooks, Attorney Fees re: Mr. and Mrs. Joe G. Kecn v. Dr. Warren A. Coleman, Eastman .....	103.55
4485—Dr. J. L. Campbell Expense Cancer Commission .....	150.00	4513—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, June 1945, less income tax withheld from June salary .....	232.40
4486—Dr. Edgar D. Shanks Travel; incidentals and expense in con- nection with Committee on Public Policy and Legislation May 1, 1944 to May 1, 1945 .....	286.00	4514—Viola Berry Salary for Executive Secretary, June 1945, less income tax withheld from June salary .....	192.00
4487—Dr. Edgar H. Greene Expense Committee on Public Policy and Legislation 1945 .....	50.00	4515—Member Pension from Benevolent Fund .....	30.00
4488—Southern Bell Telephone and Telegraph Company Service to April 21, 1945 .....	8.15	4516—Collector of Internal Revenue, Atlanta Income tax withheld from salaries April, May and June 1945. For account : Edgar D. Shanks, M. D. ....\$52.80 Viola Berry ..... 84.00	136.80
4489—A. B. Dick Comany Service on mimeograph machine .....	9.00	4517—Federal Reserve Bank, Atlanta One \$5,000 U. S. War Savings Bond, Se- ries G, and one \$10,000 U. S. War Sav- ings Bond, Series G .....	15,000.00
4490—Southern Press Clipping Bureau News clippings for March and April 1945 .....	10.00	4518—Lon F. Livingston, Postmaster Postage to cover mailings of The Jour- nal .....	50.00
4491—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of The Journal April 1945 .....	399.85	4519—Grover Middlebrooks, Attorney To retainer fee due July 1, 1945 to De- cember 31, 1945 .....	500.00
4492—Artercraft Engraving Company Cuts and mounts for The Journal ....	14.55	4520—Southern Bell Telephone and Telegraph Company Service to June 21, 1945 .....	7.80
4493—Victor Animatograph Corporation Service and parts furnished for two motion picture machines .....	72.57	4521—Georgia Power Company Repairing electric clock .....	5.00
4494—Grover Middlebrooks, Attorney Expenses to Toccoa in suit Mr. and Mrs. E. V. Loudermilk v. Dr. J. H. Terrell and Dr. C. J. Sapp .....	20.76	4522—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of The Journal June 1945 .....	443.44
4495—Pign Whistle Sandwich Shop, Inc. Expense Public Policy and Legislation ..	5.10	4523—Artercraft Engraving Company Mounts for The Journal .....	3.25
4496—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, May 1945, less income tax withheld from May salary .....	232.40	4524—Carithers-Wallace-Courtenay, Inc. Office supplies .....	4.50
4497—Viola Berry Salary for Executive Secretary, May 1945, less income tax withheld from May salary .....	192.00	4525—Atlanta Envelope Company Printing 2,525 Kraft 28 open and metal clasp envelopes .....	36.64
4498—Member Pension from Benevolent Fund .....	30.00	4526—N. I. Tyus Storage on material for scientific ex- hibits for Medical Association of Georgia, June 1944 to June 1945 .....	25.00
4499—Lon F. Livingston, Postmaster Postage .....	30.00	4527—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, July 1945, less income tax withheld from July salary .....	232.40
4500—Southern Bell Telephone & Telegraph Company Service to May 21, 1945 .....	8.52	4528—Viola Berry Salary for Executive Secretary, July 1945, less income tax withheld from July salary .....	192.00
4501—Atlanta Linen Service Linen service May and June 1945 ....	2.50	4529—Mrs. G. R. Sims Extra secretarial work May 1945 through July 31, 1945 .....	75.00
4502—Carithers-Wallace-Courtenay, Inc. Office supplies .....	4.40	4530—Member Pension from Benevolent Fund .....	30.00
4503—Southern Press Clipping Bureau News clippings for May and June 1945 ..	10.00	4531—Lon F. Livingston, Postmaster Postage .....	30.00
4504—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of The Journal May 1945 .....	427.45	4532—E. G. Brandt Electric heater .....	9.95
4505—Artercraft Engraving Company Mounts and cuts for The Journal .....	10.29	4533—Southern Bell Telephone & Telegraph Company Service to July 21, 1945 .....	8.28
4506—John B. Felder One 16" Westinghouse electric fan ....	40.00	4534—Southern Press Clipping Bureau News clippings for July and August 1945 .....	10.00
4507—Addressograph Division Addressograph supplies and service .....	10.36	4535—Franklin Printing and Manufacturing Co. Printing and mailing 2350 copies of The Journal, July 1945 .....	437.51
4508—Associated Mutuals, Inc. One year, \$3,400.00 Inland Marine In- surance on camera and projection ma- chines .....	57.80	4536—Atlanta Envelope Company Printing 49,330 Kraft 20 open end en- velopes for mailing The Journal .....	249.61
4509—Atlanta Envelope Company Printing 10,290 regular No. 10 envelopes ..	35.19		
4510—Lon F. Livingston, Postmaster Postage .....	30.00		
4511—Logan Clarke Insurance Agency, Inc. Premium on surety bonds for Secretary- Treasurer and Executive Secretary for one year, F.B. 98062-A and F.B. 161790 .....	10.00		



4537—Artercraft Engraving Company Cuts and mounts for The Journal .....	29.59	4563—Southern Press Clipping Bureau News clippings for September and Oc- tober 1945 .....	10.00
4538—Atlanta Linen Service Linen service July and August 1945 .....	2.50	4564—Artercraft Engraving Company Cuts for The Journal .....	34.24
4539—Associated Mutuals, Inc. Fire Insurance on office furniture and fixtures for \$2,000 .....	3.38	4565—Viola Berry Commission on local ads Oct. 1, 1944 to Sept. 30, 1945 .....	242.46
4540—Register of Copyrights Deposit to pay copyright fees of The Journal .....	24.00	4566—Stevens-Ideal Pictures Repairs and labor for Victor picture machine .....	23.70
4541—Grover Middlebrooks, Attorney Fee for Attorney Will Ed Smith in re: Keen v. Coleman cases, Eastman .....	375.00	4567—Frankling Printing and Manufacturing Co. Printing and mailing 2350 copies of The Journal, September 1945 .....	491.94
4542—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, August 1945, less income tax withheld from August salary .....	232.40	4568—Grover Middlebrooks, Attorney Fee Attorney T. Baldwin Martin in re: John D. Harrison v. Rhea W. Rich- ardson, Macon .....	100.00
4543—Viola Berry Salary for Executive Secretary, August 1945, less income tax withheld from August salary .....	192.00	4569—Ira A. Ferguson, M. D. Travel expenses to attend the Medical and Public Relations Meeting of the A. M. A., October 19-20, 1945, Chi- cago .....	95.00
4544—Member Pension from Benevolent Fund .....	30.00	4570—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, Octo- ber 1945, less income tax withheld from October salary .....	232.40
4545—John B. Wilson, Secretary of State of Georgia Fee for registering the Medical Associa- tion of Georgia as a Corporation .....	1.00	4571—Viola Berry Salary for Executive Secretary, Octo- ber 1945, less income tax withheld from October salary .....	192.00
4546—Southern Bell Telephone and Telegraph Company Service to August 21, 1945 .....	8.11	4572—Member Pension from Benevolent Fund .....	30.00
4547—A. B. Dick Company Semi-annual services on mimeograph machine .....	9.00	4573—Lon F. Livingston, Postmaster Postage .....	30.00
4548—Artercraft Engraving Company Cuts and mounts for The Journal .....	6.46	4574—Dr. O. H. Weaver Expenses as delegate to called meeting of the House of Delegates, A. M. A., Chicago, Dec. 3-6, 1945 .....	150.00
4549—Lon F. Livingston, Postmaster Postage .....	30.00	4575—Dr. Allen H. Bunce Expenses as delegate to called meeting of the House of Delegates, A. M. A., Chicago, Dec. 3-6, 1945 .....	150.00
4550—Lon F. Livingston, Postmaster Postage to cover mailings of The Jour- nal .....	50.00	4576—Dr. B. H. Minchew Expenses as delegate to called meeting of the House of Delegates, A. M. A., Chicago, Dec. 3-6, 1945 .....	150.00
4551—Searcy and Company Premium on fire insurance on material for scientific exhibits .....	10.00	4577—Southern Bell Telephone and Telegraph Company Service to October 21, 1945 .....	14.03
4552—Lon F. Livingston, Postmaster For postage due .....	20.00	4578—Atlanta Linen Service Linen service September and October, 1945 .....	2.50
4553—Franklin Printing & Manufacturing Co. Printing and mailing 2350 copies of The Journal, August 1945 .....	447.81	4579—Western Union Telegraph Company Telegrams .....	.80
4554—Atlanta Blue Print & Supply Company One hundred copies of Macon Audito- rium floor plan for exhibitors .....	15.00	4580—Artercraft Engraving Company Cuts for The Journal .....	2.76
4555—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, Septem- ber 1945, less income tax withheld from September salary .....	232.40	4581—Franklin Printing and Manufacturing Co. Printing and mailing 2350 copies of The Journal October 1945 .....	466.41
4556—Viola Berry Salary for Executive Secretary, Septem- ber 1945, less income tax withheld from September salary .....	192.00	4582—J. B. Richards Printing Company, Printing 2000 1946 membership cards .....	18.95
4557—Collector of Internal Revenue, Atlanta Income tax withheld from salaries July, August and September 1945 for ac- count of: Edgar D. Shanks, M. D. .... 52.80 Viola Berry .....	84.00	4583—Edgar D. Shanks, M. D., Salary for Secretary-Treasurer, November 1945, less income tax withheld from November salary .....	232.40
4558—Member Pension from Benevolent Fund .....	30.00	4584—Viola Berry Salary for Executive Secretary, November 1945, less income tax withheld from November salary .....	192.00
4559—Lon F. Livingston, Postmaster Postage .....	30.00	4585—Member Pension from Benevolent Fund .....	30.00
4560—Searcy and Company Additional premium on fire insurance on material for scientific exhibit— change of rate from \$2.00 to \$2.30....	1.50	4586—Edgar D. Shanks, M. D. Payment on expenses for special representative to attend the meeting of the House of Delegates of the A. M. A., Chicago, December 3-6, 1945 .....	150.00
4561—Southern Bell Telephone and Telegraph Company Service to September 21, 1945 .....	23.61	4587—Lon F. Livingston, Postmaster Postage .....	30.00
4562—Western Union Telegraph Company Telegrams .....	5.44		

4588—Southern Bell Telephone and Telegraph Company Service to November 21, 1945 .....	9.95	4614—Central of Georgia Railway Company Federal tax on two \$15.00 script books in exchange for advertising .....	4.50
4589—Western Union Telegraph Company Telegrams .....	2.48	4615—Southern Bell Telephone and Telegraph Company Service to January 21, 1946 .....	12.66
4590—Addressograph-Multigraph Corporation Addressograph service and supplies .....	14.30	4616—Atlanta Linen Service Linen service December 1945 and January 1946 .....	2.50
4591—Franklin Printing and Manufacturing Company Printing and mailing 2350 copies of The Journal November 1945 .....	529.02	4617—Southern Press Clipping Bureau News clippings for November and December 1945 .....	10.00
4592—A. B. Dick Company Mimeograph supplies .....	12.19	4618—Carithers-Wallace-Courtenay, Inc. Office supplies .....	8.00
4593—Carithers-Wallace-Courtenay, Inc. Office supplies .....	9.70	4619—Arctcraft Engraving Company Cuts for The Journal .....	24.91
4594—Arctcraft Engraving Company Cuts for The Journal .....	2.88	4620—Franklin Printing and Manufacturing Company Printing and mailing 2262 copies of The Journal January 1946 .....	522.55
4595—Dr. Cleveland Thompson Honorarium for President 1945-1946 .....	300.00	4621—The National Library Bindery Company Binding 12 volumes of The Journal 1945 .....	29.40
4596—Dr. W. A. Selman Expenses 1945 for Committee on Pro- curement and Assignment for Physi- cians .....	100.00	4622—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, February 1946, less income tax withheld from February salary .....	238.60
4597—Dr. John B. Fitts Expenses 1945 for Committee on Procurement and Assignment for Physicians .....	100.00	4623—Viola Berry Salary for Executive Secretary, February 1946, less income tax withheld from February salary .....	197.20
4598—Eddie Thompson Janitor service May 1 to December 31, 1945 .....	35.00	4624—Member Pension from Benevolent Fund .....	30.00
4599—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, December 1945, less income tax withheld from December salary .....	232.40	4625—Lon F. Livingston, Postmaster Postage .....	40.00
4600—Viola Berry Salary for Executive Secretary, December 1945, less income tax withheld from December salary .....	192.00	4626—Franklin Printing and and Manufacturing Company Printing and mailing 2400 copies of The Journal February 1946 .....	553.64
4601—Member Pension from Benevolent Fund .....	30.00	4627—J. D. Grant Storage and moving material for scientific exhibit for Medical Association of Georgia .....	22.50
4602—Mrs G. R. Sims Extra secretarial work August 1945 through December 1945 .....	125.00	4628—Southern Bell Telephone and Telegraph Company Service to February 21, 1946 .....	12.76
4603—Lon F. Livingston, Postmaster Postage .....	40.00	4629—Atlanta Linen Service Linen service February and March 1946 .....	2.50
4604—Collector of Internal Revenue, Atlanta Income tax withheld from salaries, October, November and December 1945: For account of: Edgar D. Shanks, M. D. .... 52.80 Viola Berry .....	84.00	4630—Arctcraft Engraving Company Cuts for The Journal .....	15.75
4605—Southern Bell Telephone and Telegraph Company Service to December 21, 1945 .....	12.16	4631—A. B. Dick Company Service on mimeograph machine .....	9.00
4606—Western Union Telegraph Company Telegrams .....	3.38	4632—Addressograph-Multigraph Corporation Addressograph service and supplies .....	7.35
4607—Thompson Engraving Company Printing 1800 postal cards .....	25.00	4633—Reeves Studios Photos for the Convention Number of The Journal .....	10.00
4608—Franklin Printing and Manufacturing Company Printing and mailing 2500 copies of The Journal December 1945 .... 591.84 Printing 2500 dues cards .... 12.75	604.59	4634—Lon F. Livingston, Postmaster Postage .....	30.00
4609—Grover Middlebrooks, Attorney To retainer fee January 1, 1946 to July 1, 1946 .....	500.00	4635—Railway Express Agency Express on moving picture machine ....	2.60
4610—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, January 1945, less income tax withheld from January salary .....	238.60	4636—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, March 1946, less income tax withheld from March salary .....	238.60
4611—Viola Berry Salary for Executive Secretary, January 1946, less income tax withheld from January salary .....	197.20	4637—Viola Berry Salary for Executive Secretary, March 1946, less income tax withheld from March salary .....	197.20
4612—Member Pension from Benevolent Fund .....	30.00	4638—Mrs. G. R. Sims Extra secretarial work January 1, 1946 through March 31, 1946 .....	75.00
4613—Lon F. Livingston, Postmaster Postage .....	30.00	5639—Member Pension from Benevolent Fund .....	30.00
		4640—Collector of Internal Revenue, Atlanta Income tax withheld from salaries January, February and March 1946: For account of:	



Edgar D. Shanks, M. D.	34.20	
Viola Berry	68.40	102.60
4641—Lon F. Livingston, Postmaster Postage		40.00
4642—Lon F. Livingston, Postmaster Postage to cover mailing of The Journal		50.00
4643—Southern Bell Telephone and Telegraph Company Service to March 21, 1946		12.25
4644—Western Union Telegraph Company Telegram		.83
4645—Arctcraft Engraving Company Cuts for the Convention Number of The Journal		20.80
4646—Richardson and Kock Printing 5,000 registration cards		17.50
4647—Addressograph-Multigraph Corporation One belt and service on graphotype machine		5.26
4648—Carithers-Wallace-Courtenay, Inc. Office supplies		12.65
4649—Atlanta Envelope Company Printing 2500 envelopes for mailing proof		20.73
4650—Franklin Printing and Manufacturing Company Printing and mailing 2500 copies of The Journal and reprints		685.03
4651—Edgar D. Shanks, M. D. Salary for Secretary-Treasurer, April 1946, less income tax withheld from April salary (outstanding)		238.60
4652—Viola Berry Salary for Executive Secretary, April 1946, less income tax withheld from April salary (outstanding)		197.20
4653—Member Pension from Benevolent Fund (outstanding)		30.00
Exchange on non-par checks		10.80
TOTAL		\$32,821.28

### NEWS ITEMS

The Baldwin County Medical Society held its regular meeting at the Milledgeville State Hospital, Milledgeville, May 1. The meeting was called to order by the President, Dr. Z. S. Sikes. Members present were Dr. Z. S. Sikes, Dr. M. Fernan-Nunez, Dr. S. A. Anderson, Dr. T. C. Clodfelter, Dr. W. A. Bostick, and Dr. J. D. Combs. Guests were: Drs. McArthur, W. Sikes and Frank Mitchell, Jr. Dr. S. A. Sanchez was accepted into membership. The Sixth District Medical Society was invited to Milledgeville for the summer meeting.

Dr. William E. Brown, Greensboro, announces the opening of his office at Lumpkin for the practice of medicine. Dr. W. V. Roherts, Augusta, also announces the opening of offices at Lumpkin for the practice of medicine.

Dr. J. W. Butts, formerly of Waterloo, Iowa, has established his medical practice at Americus.

Dr. T. H. Clark, Douglas, was recently elected president of the State Board of Medical Examiners for the year 1947. The board is a ten-man professional committee appointed by the Governor. Dr. Clark has served on the board for a period of three years.

Dr. H. W. Clements and Dr. L. R. Hutchinson, Adel physicians, recently received from President Truman commendation for their services as members of the Selective Service Board during the war.

Dr. James B. Craig, formerly of Augusta, announces his release from the Army Medical Corps and the opening of his office for the practice of medicine at 19 West Gordon Street, Savannah.

Dr. W. Ben Davis, College Park, announces his return from military service and the re-opening of offices at 115 South Main Street, College Park. Practice limited to infants and children.

The Murdock Equen Scholarship of the Thomas A. Edison Foundation was created by the board of directors of that foundation at a recent meeting in Washington. It is named in honor of Dr. Equen, 1944 recipient of the Thomas A. Edison Foundation Gold Award for Achievement. The scholarship is permanent and "is named for Dr. Equen in view of his great achievement in science and laryngology, and his contribution to the development and use of the Alnico magnet for the removal of foreign bodies from the stomach and lungs."

Dr. Henry Fenn, a native of Cordele, announces the opening of offices in the Wise-Smith Clinic Building, Americus, and will be associated with Dr. H. A. Smith in the practice of general medicine and surgery.

Dr. I. S. Giddens, formerly of Millen, announces his return from military service and the opening of his offices with Dr. L. R. Hutchinson, Adel, for the practice of medicine and surgery.

Dr. Lester Harbin, Rome, recently released from the U. S. Army Medical Corps, has resumed his duties on the staff of Harbin Hospital, Rome.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, May 14.

Dr. Clair A. Henderson, former Terrell County health officer, has been awarded the 1945 Lucas trophy for having done the most worth-while thing during the year for Savannah, where he is currently serving as city and county health officer. He was selected for Savannah's leadership in the unprecedented campaign against tuberculosis and venereal disease, which saw 71,149 persons voluntarily submit to chest x-rays and blood tests in a 45-day period last fall.

Dr. James M. Hicks, Brunswick, recently discharged from the Medical Corps of the U. S. Army, has reopened his offices in the Andrews Building, Gloucester Street, Brunswick, for the practice of medicine.

Dr. A. S. Johnson, Jr., Elberton, announces his association with his father, Dr. A. S. Johnson, Sr., and his cousin, Dr. J. E. Johnson, Jr., Elberton, for the practice of medicine.

Dr. George L. Johnson, former manager of the Veterans' Hospital at Tuscaloosa, Alabama, has been named manager of Finney General Hospital, Thomasville, which the Veterans' Administration has taken over from the Army.

Dr. C. E. Leaphart, Jesup, announces his return from military service, and has become a member of the staff of the Colvin-Ritch-Leaphart Hospital, Jesup. Dr. Leaphart is the brother of Dr. J. A. Leaphart, Jesup.

Dr. John T. Leslie, Decatur, announces his return from military service and the opening of his office for the practice of pediatrics, 121 Clairmont Avenue, Decatur.

Dr. Julian Lokey, Augusta, having completed a nine months' residency in the department of internal medicine at the University Hospital, Augusta, will serve as chief resident in medicine until July 1, 1947.

Dr. J. Zeb McDaniel, formerly of Augusta and Camilla, recently released from the Army Air Forces, announces his association with Dr. J. C. Keaton, Albany. Practice limited to urology.

Dr. W. F. McKemie, Albany, recently released from the Medical Corps of the United States Army, is associated in the practice of medicine with his uncle, Dr. H. M. McKemie, Albany.

Dr. Buford L. O'Neal, Atlanta, announces opening of offices, associated with Dr. Herschel C. Crawford, 705 Doctors Building, Atlanta. Practice limited to eye, ear, nose and throat.

Dr. J. C. Pirkle, formerly of Austell, announces the opening of offices on Mathewson Avenue, Pelham, formerly occupied by the late Dr. M. M. Burns, for the practice of medicine and surgery.

Dr. Roy Pope, Chickamauga, recently returned from the Army Medical Corps, has resumed his medical practice and is associated with Dr. H. F. Shields, Sr., Chickamauga.

Dr. Paul T. Russell, Albany, recently discharged from military service, has opened offices at 222½ Doctors Building, Albany, for the practice of medicine.

Dr. W. A. Shimmel, Unadilla, recently discharged from the Army after 44 months' service with the Medical Corps, has become a member of the staff of the Dooly Hospital, and has opened offices for the practice of medicine and surgery, Unadilla.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, June 6. Program: Case Report, "Adrenallike Masculinizing Tumor and Ovary Associated with Bleeding Fibromyomatous Uterus," Dr. Geo. A. Williams and Dr. W. A. Mendenhall. Paper: "Pneumococcic Meningitis, with Report of Cases," Dr. Joseph C. Massee. Discussion: Dr. Paul Beeson and Dr. Edgar F. Fincher. Following the program, Mr. W. H. Owen, associated with Parke-Davis Company, showed a moving picture entitled "Scalp Avulsion."

Dr. C. W. Roberts, Atlanta, recently read a paper entitled "Four Dimensional Medicine" at the annual session of the Medical Association of North Carolina, Pinehurst, North Carolina.

Dr. Leo Smith, Waycross, announces his return from military service and will resume his practice, limited to the eye, ear, nose and throat, at 901 Jane Street, Waycross.

The Executive Committee of the Council of the Southern Medical Association, at a special meeting in St. Louis on May 13, accepted the invitation of the Florida State Medical Association and the Dade County (Miami) Medical Society to hold the next annual meeting of the Southern Medical Association in Miami, November 4-7.

Dr. Trawick W. Stubbs, Atlanta, Emory University School of Medicine graduate and Army Medical Corps veteran, was recently appointed assistant dean of the Emory University School of Medicine, Emory University.

Colonel John Allen Thurston, Atlanta, was recently promoted from the rank of lieutenant colonel in the Army Medical Corps. Colonel Thurston, who will soon retire, is chief surgeon at the Veterans Hospital No. 48 in Atlanta, and has served in the Army continuously since World War I. He is a member of the American College of Surgeons.

Emory University, Atlanta, officially honored the medical staffs of its two famous "Emory Units," general hospitals which served in both World Wars, at a dinner at the Biltmore Hotel, May 30. Two plaques, commemo-

rating the services of these units, were unveiled and will be placed in the Emory University Hospital. Headed by Dr. F. K. Boland, Sr., and Dr. C. W. Strickler, Sr., 26 members of the World War I unit were invited. Fifty-three members of the Forty-Third General Hospital staff, with Dr. Ira A. Ferguson, former commander, as senior officer, represented the World War II unit. Mr. Preston S. Arkwright, of the Emory Board of Trustees, served as toastmaster.

Dr. B. F. Williams, formerly of Atlanta, has opened offices in the Middlebrooks Building, Barnesville, for the practice of medicine.

Dr. William D. Wilson, Savannah, was recently appointed as medical adviser to the first aid committee of the Savannah Chapter of the American Red Cross. In this capacity Dr. Wilson will act as counselor and guide to first aid instructors and maintain active liaison with the medical profession.

Dr. M. E. Winchester, of Brunswick and Glynn County, has been elected president of the Georgia Public Health Association, succeeding the able Dr. Abe Davis, of Augusta.

This is but one of the many honors that have come to the man, not a few of them of national scope. But this one, we know, he appreciates most. He is a part of the Georgia scene.

A dramatic and forceful worker, he tore into the problem of malaria and venereal disease in his coastal section in a manner which reduced the prevalence of both diseases to the irreducible minimum. His "Bad Blood Wagon" penetrated the piney woods and went on ferries to islands. He was the first to persuade his county to put into effect a real health ordinance for eating places.

The result of all the work by him and his competent staff was that during the period of swollen population and drifting war workers, Brunswick and Glynn County had no epidemics, no breakdown in the splendid system of public health measures.

Long may you wave, Doctor, and may the good work go on.—*Atlanta Constitution*, editorial page, April 1946.

Dr. Rudolph Bell, Thomasville, was recently elected president of the Georgia Urological Association. Other officers chosen were: Dr. W. E. Upchurch, Atlanta, president-elect; Dr. R. C. Coleman, Atlanta, secretary-treasurer, and the following members of the Executive Committee: Dr. Lovick W. Pierce, Waycross; Dr. J. Zeb McDaniel, Albany, and Dr. W. R. Golsan, Macon. Dr. Stephen T. Brown, Atlanta, president of the Georgia Urological Association, presided. Dr. Oswald Swinney Lowley, New York, was honor guest.

Dr. Charles K. Howard, Atlanta, recently released from the U. S. Navy after serving 26 months in the Medical Corps, has resumed the practice of medicine and surgery at 561 Lee Street, S. W., Atlanta.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, May 28. Program: "Anesthesia," by Dr. W. L. Osteen. Report on Hospitalization Service of Savannah, by Dr. M. J. Egan.

The Atlanta Eye, Ear, Nose, and Throat Society met at the Academy of Medicine, Atlanta, May 17. Program: "Important Points in the Anatomy of the Oculomotor Nerve." A Survey of Ophthalmic Literature, by Dr. Z. W. Jackson. "The Lempert Institute of Otolology," Comments by Dr. Lester A. Brown. "Pro's and Con's of the Use of Radium in Lymphoid Hyperplasia of the Nasal Pharynx," Dr. Paul S. Mertins, Montgomery, Ala. Discussion: Dr. James T. King and Dr. Fred Ogden. Dr. B. McH. Cline is the president.



Dr. Lewis H. McDonald, Atlanta, recently discharged from the U. S. Army Medical Corps, after four years of service, has resumed his practice of medicine and surgery, with offices in the Medical Arts Building, Atlanta.

Dr. Robert Battey Crichton, Lithonia, announces the opening of his offices on the second floor of the Stewart Building, Lithonia, for the practice of obstetrics.

Dr. Daniel E. Nathan, Fort Valley, recently released from the Medical Corps of the U. S. Army Air Force, has opened offices in the Evans Building, Fort Valley, for the practice of medicine.

Dr. Everard A. Wilcox, Augusta, has returned from military service in the Army and resumed the practice of general surgery, Doctors Building, 1345 Greene Street, Augusta.

Dr. Everett L. Bishop, Atlanta, served as referee for the Tumor Seminar at the invitation of the Florida Pathological Society at their eighth annual meeting, which was held in Jacksonville in April.

The American Association for the Study of Goiter met at the Drake Hotel, Chicago, June 20, 21, 22, 1946.

The Georgia Baptist Hospital staff dinner meeting was held in the Nurses' Home Dining Room, Atlanta, May 21. The business session was held in the clinic.

The American Broncho-Esophagological Association met recently in Chicago. The following officers were elected: President, Dr. Robert M. Lukens, Philadelphia; vice-president, Mr. Murdock Eguen, Atlanta; and secretary, Dr. Paul H. Holinger, Chicago.

Dr. Abraham S. Velkoff, Atlanta, announces the opening of his office at 26 Linden Avenue, N. E., Atlanta. Practice limited to obstetrics and gynecology.

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, June 4. Dr. C. K. McLaughlin was in charge of the program.

#### OBITUARY

Dr. Everett Daniel, aged 73, widely known physician and surgeon of Moultrie, died April 12, 1946. Dr. Daniel was born at Boston, Ga., son of the late Dr. and Mrs. Ben W. Daniel. He graduated from Emory University School of Medicine, Atlanta, in 1892. He moved to Moultrie soon after his graduation and served as chief surgeon of the Georgia Northern Railway Company for a number of years. He was a member of the Colquitt County Medical Society and the Medical Association of Georgia, was a fellow of the American Medical Association, and a member of the First Baptist Church. Surviving are two sons, Ben W. Daniel and Lucien Daniel, both of Moultrie; a brother, three sisters, and three grandchildren. Funeral services were held at the residence, 202 Second Avenue, with Dr. R. C. Gresham and Rev. R. L. Forbes, Jr., officiating. Burial was in Westview Cemetery, Moultrie.

Dr. Ben H. Howard, aged 67, Dawsonville and Dawson County's only physician, died at his home, May 7, 1946. Dr. Howard was born in Lumpkin County. He graduated from the Atlanta School of Medicine in 1909, and had practiced medicine in Dawsonville and Dawson County for 37 years. He was a member of the Dawsonville Methodist Church and of the Masonic order. Survivors are his wife, Mrs. Ben H. Howard; one son, Dr. Marcus Howard; three daughters, Mrs. Marjorie Tatum, Dawsonville; Mrs. Claude Roark, Gainesville; Mrs. Bert Allison, Culver City, Cal.; two brothers, Lewis Howard, Winder, and Dr. I. B. Howard, Williamson. Funeral services were held at the Dawsonville Methodist Church, with the Rev. J. G. Lupo, pastor, officiating. Burial was in the City Cemetery, Dawsonville.

Dr. Seals Leftwich Whitely, aged 66, Cedartown, prominent surgeon and founder of Cedartown's first hospital, died March 29, 1946. Dr. Whitely was a native of Rome, the son of Mrs. Charles H. Whitely and the late Mr. Whitely. He was graduated from Tulane University School of Medicine, New Orleans, in 1906. He had practiced medicine in Polk County for many years, operating the Whitely Hospital. He was a member of the Polk County Medical Society, the Medical Association of Georgia, the American Medical Association, and the First Presbyterian Church. Survivors include his wife, Mrs. Irene Dempsey Whitely; his mother, Mrs. Charles H. Whitely, both of Cedartown; five daughters, Alberta, Gertrude, Edna, Elizabeth, and Ida Mae Whitely; one son, Seals L. Whitely, Jr., and two aunts. Funeral services were held at the First Presbyterian Church, with Rev. E. P. Nichols officiating. Burial was in Greenwood Cemetery, Cedartown.

Dr. George P. Willbanks, aged 88, Rossville, died April 2, 1946. He was graduated from Emory University School of Medicine, Atlanta, in 1883. Dr. Willbanks was a practicing physician for 60 years, the greater part of which time was spent in Rossville. He was a member of Hamilton County-Chattanooga Medical Society, the Tennessee State Medical Association, the Rossville Lodge F. & A. M., the Ridgedale Commandery, the Alhambra Shrine, and the McFarland Memorial Methodist Church. Surviving are his wife, Mrs. Annie Dixon Willbanks, and one daughter, Miss Bonnie Willbanks, of Chattanooga. Funeral services were held at the McFarland Memorial Methodist Church, with Rev. J. L. Chaney and Rev. Paul Martin officiating. Burial was in the Forest Hills Cemetery, Rossville.

#### IRON DEFICIENCY ANEMIA MISTAKEN FOR VITAMIN B COMPLEX DEFICIENCY

Iron deficiency anemia is frequently confused with vitamin B complex deficiencies, according to William J. Darby, M. D., of Nashville, Tenn., writing in the March 30 issue of *The Journal of the American Medical Association*.

Dr. Darby, who is from the Department of Medicine, Vanderbilt University School of Medicine, presents the case reports of six patients who showed no abatement of symptoms after treatment with B vitamins. These same patients were then treated with iron and almost immediate improvement was noted.

Iron is a necessary part of hemoglobin, the red coloring matter of the blood. The symptoms of iron deficiency are manifested by a mild anemia, inflammation of the tongue and sometimes an inability to swallow. Iron deficiency anemias are more common among women than men.

#### WAR AND LOW FACULTY PAY CUT MEDICAL EDUCATION STANDARDS

*A.M.A. Journal Says Inadequate Salaries Are Partly Due to Decreased Endowment Income*

In an editorial entitled "Financial Support of Medical Schools," *The Journal of the American Medical Association* anticipates a serious lowering of standards in medical education.

"The war dealt a serious blow to the quality of medical education," *The Journal* says in its April 27 issue, adding: "The failure of the Selective Service System to provide for the training of scientists has already resulted in a serious

deficiency of instructors, particularly in preclinical subjects. The rosters of candidates for Doctor of Philosophy degrees in our larger universities have been largely nonexistent for some four or five years.

"A further threat to the quality of medical education lies in financial developments involving the budgets of our medical schools. Dr. Frank E. E. Germann pointed out in a recent issue of *Science* that the current salaries in effect for instructors in science are such as to make it virtually impossible to attract qualified men and women to these institutions as teachers. He says, 'A small number of our highly endowed educational institutions have been able to hold and attract outstanding scholars because of their higher salary scales, but the average private or state-supported institution has been forced into mediocrity.' He asks, 'What future can we promise young men and women holding pre or post-doctoral fellowships at \$1,800 to \$3,000 when we still offer \$2,000 for assistant professors and require that they have the doctorate degree? What chance do we have to secure a competent teacher in science when a full professor, after thirty years of service, may never reach a salary of \$4,000?'

"The failure to provide adequate salaries can be attributed in part to the decreased endowment income of recent years, which, estimates indicate, has lost the medical schools about one-third of their endowed income. Other factors are operating to reduce funds available to pay teachers in medical school. Faculties are being increased in numbers with the return of men who have been on leave for military or other government assignments. Income from fees for tuition will decrease, sharply in some instances, because the deceleration of the medical curriculum will provide fees to the school for only three-fourths of the calendar year instead of the entire year. Fees collected will also be reduced by reductions in enrolments. State schools will receive smaller sums because the Army and Navy medical school programs paid out-of-state tuition fees which are often considerably greater than the fees charged residents of the state in normal times. With the termination of the military medical school programs, these state universities will be returning to the normal lower fee schedule.

"As a result of these developments a serious lowering of standards in medical education may be anticipated. Every means must be explored to combat such tendencies. Increased endowments must be sought, perhaps especially from industry, which benefits largely from improvements in science instruction and research. The financial structure of most of our states is now such that considerably increased sums could be employed in medical education without greatly taxing state resources. Bills now pending before Congress provide primarily for the support of scientific research and training fellowships. Little if

any consideration is given to the equally important financial strengthening of our whole structure of medical education. An annual budget of \$350,000 for a small medical school may be the minimum goal which should be sought by all medical schools. Unfortunately, an appreciable number of our medical schools has not reached this minimum standard."

#### LARGE DOSES OF VITAMIN D MAY CAUSE DEATH BY CALCIFYING TISSUES

Vitamin D in massive doses may cause death. It produces cell injury followed by calcium deposition, according to two physicians who report the case of the only female adult known to have died as the result of this calcifying action.

Writing in the April 27 issue of *The Journal of the American Medical Association*, Jere M. Bauer, M. D., Instructor in Medicine, University of Michigan Medical School, and Richard H. Freyberg, M. D., Associate Professor of Clinical Medicine, Cornell University, and Director of the Department of Internal Medicine, Hospital for Special Surgery, New York, say that "In the human being death may occur, even in the adult, as a result of vitamin D intoxication causing calcification of organs and arteries.

Metastatic calcification results from the deposition of lime salts in a tissue or part at the same time that marked decalcification of the bones is taking place. Most previously reported cases were boy infants from 4 to 18 months old. The vitamin D preparations given to them had included simple fortified cod liver oil, ultraviolet irradiated ergosterol which comes in a crystalline form and electrically activated vaporized ergosterol.

The most frequent symptoms of vitamin D poisoning are loss of appetite, nausea and vomiting, diarrhea, muscular weakness, lassitude and headache.

The kidney seems to be the most vulnerable of any tissue to the calcifying action of vitamin D. However, the lungs, stomach, arterial vascular system and myocardium or heart muscle are also involved, according to Drs. Bauer and Freyberg.

Citing the work of other investigators, the authors point out that the "factors which influence the toxicity of vitamin D are the dose per unit of body weight, the route and duration of administration, the composition of the diet in regard to the mineral and organic contents, the state of the alimentary tract, species susceptibility, age, preexisting pathologic conditions, the vehicle in which the vitamin is administered, the state of the endocrine system, the purity of the vitamin preparation, the source of the vitamin and other factors not yet recognized."

In recent years large doses of vitamin D preparations have been prescribed for the treatment of a wide variety of diseases, including arthritis, hay fever, vitamin D deficiency, psoriasis, a skin disease, acne, and trichonosis, a disease of the hair.

In conclusion Drs. Bauer and Freyberg say: "It is regrettable that . . . these potentially toxic preparations . . . have been sold to the public without need for prescription."

#### THE ELEVENTH U. S. P. XII SHEET SUPPLEMENT

It has been found necessary to issue another Pharmacopoeial Sheet Supplement to meet changing conditions. Pharmacists and customers generally will appreciate the return to the pre-war formula for Liniment of Soft Soap in which Oil of Lavender is the perfume. The war-time substitution of Oil of Cedar was never a popular change.



# *THE JOURNAL* OF THE *MEDICAL ASSOCIATION OF GEORGIA*

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## THE EARLY DIAGNOSIS OF NEUROSURGICAL LESIONS

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Mayo Clinic,  
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A distinct honor was conferred on me by my friend and traveling companion, Dr. James Paullin, when he asked me to address you on this the one-hundredth anniversary of the birth of Abner Wellborn Calhoun, for whom this lectureship has been named. It allows me the opportunity of paying tribute to Dr. Calhoun and through him to the medical specialty, ophthalmology, to which he contributed so greatly. Most of you, I am sure, are aware of the debt of gratitude which we neurologic surgeons owe to the ophthalmologists, for the ophthalmoscope and the perimeter have made possible earlier diagnosis of lesions within the cranial cavity. Earlier diagnosis has allowed for earlier surgical treatment, which has lowered the mortality rate and made possible the removal of tumors before irreparable damage has occurred to the neighboring brain and cranial nerves. The careful examination of the eye has become one of the essentials in neurologic diagnosis, for frequently during this examination changes in pupillary reflexes, sensation of the cornea, motion of the eyeball, and fundi and visual fields prove to be a clue to the presence of intracranial lesions and the remaining examination stems from these findings.

Of equal importance is the general physical examination, for intracranial lesions may be associated with systemic disorders and primary malignant lesions elsewhere. The roentgenologic examination of the head, thorax and spinal column is essential. Of

probably more importance is the complete and comprehensive neurologic examination, noting any change in reflexes, motor and sensory abnormalities, any deviation from the normal in posture and gait, state of equilibrium and mental acuity.

The usual cardinal symptoms of intracranial lesions are headache, nausea and vomiting, and visual loss, which symptoms are produced by increased intracranial pressure due either to tumor of the brain or to inflammatory lesions such as arachnoiditis and abscesses.

Headache is the most common of these symptoms, although many brain tumors grow to a considerable size without producing it. More than half of the headaches resulting from increased intracranial pressure are not localized to a definite region or even to one side of the head, but are diffuse. Generalized headaches caused by intracranial pressure are described as deep and expanding; seldom are they continuous; they occur intermittently, usually in the morning or every two or three days, and may be relieved by vomiting. Headaches of psychogenic origin are usually more superficial, more radiating, more constant and unremitting than those caused by intracranial pressure. They may be stabbing, boring and confined to the top of the head or occipital region, producing a sense of tightness of the occipital muscles. Migraine headaches may be general or confined to a half of the head; they come in attacks lasting from half a day to four days and are associated with nausea, vomiting, and sometimes visual disturbances such as hemianopsia or scotomata.

Vomiting associated with brain tumor usually occurs at the peak of the headache and is followed by relief of the headache; it may or may not be associated with nausea, but it is not related to eating of food. Explosive or projectile vomiting, while not essential, is suggestive of intracranial pres-

sure. The relief of headache by vomiting is much more suggestive of brain tumor than the character of the vomiting.

The third cardinal symptom has to do with the eyes and may be indicated by loss of visual acuity. It is this symptom that the ophthalmologist has interpreted in terms of intracranial changes and thus has aided in the early diagnosis. An examination of the eye grounds is necessary to determine the presence of papilledema or choked disk. It has been said that an ophthalmoscope is of more importance in diagnosing lesions of the brain than the stethoscope in diagnosing lesions of the thorax. Papilledema may be due to intracranial pressure or optic neuritis. The former indicates an intracranial lesion. Papilledema may be present in cases of hypertension, acute and chronic nephritis, multiple sclerosis, endocarditis, diabetes, myopia and hyperopia.

Convulsions may indicate increased intracranial pressure or localization of the lesion. Tonic convulsions seem to arise from a lower level in the brain than that from which the clonic type arises. Whenever the convulsions involve one side of the face, arm or leg, they are of localizing value and indicate a lesion involving the contralateral motor area. Convulsive seizures occurring after adolescence which are not due to toxic or constitutional disorder should be looked on as suggestive of tumor of the brain.

It is sometimes very difficult to recognize the early symptoms of tumors of the brain in children, in view of the fact that children often complain of headache, nausea and vomiting. While it is true that many tumors in children are very malignant and palliative operation only can be carried out, quite frequently the more benign tumors can be successfully removed.

Such a case was that of a boy aged four years who for six months had had transitory headaches coming on any time of the day and lasting only a few minutes. One month before his examination the headaches became very severe and involved the entire head. They were accompanied by extreme weakness and profuse perspiration. Ten days before his examination he began to vomit every day and soon began to stagger occasionally when walking. His head was tilted to the left and he staggered toward the right. His examination revealed a bilateral choked disk of 4 diopters, left convergent strabismus, ataxic gait and positive Romberg sign. A loud bruit could be heard over both mastoid regions. A diagnosis of cerebellar tumor was made and at operation a large cystic, degenerating astrocytoma containing 70 c.c.

of yellow fluid was found. When the cyst was opened, a large mural nodule was found involving the left inferior tonsil which was completely removed. Two and a half years later the boy was enjoying perfect health, was in the second grade at school, and his teacher reported him as an average student.

A short history, especially in children, is usually indicative of a malignant tumor. However, the brevity and severity of the symptoms should never indicate a discouraging prognosis until the pathologic nature of the lesion has been determined.

This is illustrated by the case of a girl aged seven years, who following chickenpox and measles had a headache for fifteen days and double vision for ten days prior to the time of her examination. Three days before she was seen she began to have projectile vomiting and complained of a full stomach. She was found to have a bilateral choked disk of 3 diopters with a mild internal strabismus on the right. Neurologic examination revealed nystagmus, ataxia and incoordination, associated with a mildly stiff neck. There was an audible bruit over the occiput and left temporal region. In spite of the short history following infection a diagnosis of brain tumor was made and cerebellar craniotomy was performed. A large tumor could be seen filling the fourth ventricle and apparently coming from the left inferior tonsil. The tumor was dissected free and removed with the involved portion of the brain. On microscopic examination it proved to be an oligodendroglioma. Following the operation, the girl made an uneventful convalescence. On dismissal her papilledema was receding, the headaches were relieved and the strabismus had almost entirely disappeared.

The preoperative possibilities in this case, of course, were inflammatory arachnoiditis or a rapidly growing tumor, very malignant in character, for which only palliative procedures could be used. However, the radical removal of a benign type of tumor which was found at operation allowed this patient to go several years without any return of symptoms. When seen a few months ago, she was attending school, was perfectly normal in every way and was making straight A grades.

Probably the most difficult tumors of the brain to diagnose and operate on in the early stages of development are the meningiomas or the benign fibroblastic neoplasms sometimes called "endotheliomas." Occurring frequently in the so-called silent areas of the brain, they may masquerade as epilepsy, diffuse headaches, or change in personality and require ventriculography in order to establish a diagnosis. When they occur in areas which subserve definite functions, these tumors localize themselves quite early and, therefore, are amenable to more successful surgical treatment.

Such a case was that of a woman aged thirty-seven years. She was unusually intelligent and was an accomplished musician. She had been perfectly well until three months before her examination, when she began to be a little mentally confused, noticed that she had to seek for the word to express herself, and a few months later noticed numbness and weakness of the right hand and arm. Her difficulty in speech increased until she was definitely aphasic and there was a definite weakness in the entire right side. She had had four jacksonian convulsions involving her right arm and hand.



Roentgenologic examination of the head revealed an area of erosion over the left parietal region. Her perimetric fields and fundi were normal. There was a definite weakness of the entire right half of the body, with increased reflexes of the extremities. Disability was so great that she was confined to her bed. The aphasia, jacksonian convulsions and right hemiparesis indicated a rapidly growing tumor near the cortex in the left temporoparietal region. The roentgenogram of the head showing erosion of the inner table suggested a meningioma. At operation a cortical tumor was found. It was removed from the postfrontal and parietal regions near the vertex corresponding to the shadow in the roentgenogram. The tumor proved to be a meningioma measuring 6 by 4 by 3 cm. On the third postoperative day there was definite improvement in the entire right side, but her aphasia persisted until about the sixth day when she was able to express herself. In three weeks she was walking and while her speech was rather slow, there was marked improvement in her choice of words.

In contrast to the meningiomas, it is found sometimes that tumors with a short history are rapidly growing malignant gliomas and, in spite of the fact that they are diagnosed early and completely removed, they tend to recur in a comparatively short time.

Such a case was that of a woman who had a short history of two months, starting with headaches which occurred in the evening; they were severe for two or three hours and then disappeared. A month and a half later she began to have projectile vomiting and at the same time noticed a weakness of the right arm and leg. On examination the roentgenogram of the head showed a shifting of the pineal shadow to the left. The perimetric fields were normal, but the fundi showed papilledema of 1 diopter. There was marked weakness of the entire left half of the body with increased reflexes. At operation a fairly well-demarcated malignant tumor was found in the right frontoparietal region. The tumor was completely removed. On microscopic examination it proved to be a glioblastoma multiforme, the most malignant type of glioma. Although all of the tumor was removed, a recurrence is to be expected. The patient's postoperative course was very satisfactory; the hemiparesis persisted for a period of six weeks and then gradually cleared up.

There are tumors within the intracranial cavity the early symptoms of which are not those of increased intracranial pressure but are due to pressure on certain cranial nerves or isolated areas of the brain. In this group are tumors of the pituitary gland and other lesions about the optic chiasm and tumors in the cerebellopontine angle.

Pituitary tumors have a symptomatology which involves the vision and the endocrine system. Sometimes the first indication of pituitary tumors in women is due to endocrine dysfunction and is indicated by amenorrhea. Patients suffering from pituitary tumors or tumors about the optic chiasm may complain of visual difficulties and have repeated examinations of the eyes before the lesions are recognized. Fre-

quently their glasses are changed until the vision is almost lost and the optic nerves are irreparably damaged before a diagnosis is made. Then, of course, the removal of the pituitary adenoma does not restore normal vision because of the optic atrophy. Probably in no other group of tumors of the brain is an early diagnosis so important, because if the lesion is recognized early and operation is carried out, the mortality rate is very low, the chances for recovery are better and restoration of the normal endocrine function is possible.

Such a case was that of a woman aged twenty-six years who had had amenorrhea for two years and difficulty with vision for six months. She described her difficulty in vision as being unable to see in the upper outer half of the eyes. Her examination was negative except for lowered basal metabolic rate and bitemporal quadrant hemianopsia. On account of the amenorrhea, bitemporal hemianopsia and lowered basal metabolic rate, the diagnosis of pituitary tumor was made. At operation a chromophobe adenoma of the anterior lobe of the pituitary was found. This was removed and twelve days after operation her visual fields had returned almost to normal. Menstruation began eighteen months after operation. She was subsequently married, had two children and nine years later was in perfect health.

The ultimate results in this case are due primarily to the fact that operation was carried out before the tumor had produced any permanent damage to the optic nerves or to the pituitary gland, illustrating the advantage of early diagnosis.

Probably the earliest diagnosis of tumor of the pituitary gland was not made by the neurologist or the ophthalmologist, but by an obstetrician.

A patient aged thirty-four years came to the Mayo Clinic complaining of sterility. She had been pregnant four years before and had been delivered of a normal baby who died in infancy. Since her pregnancy she had never menstruated. Her general examination was negative and there was some question of premature menopause. However, the obstetrician suspected an endocrine dysfunction and a determination of the basal metabolic rate was obtained. This was normal, but a roentgenogram of the head disclosed a markedly enlarged sella turcica. Subsequent examination of the perimetric fields revealed an upper quadrant bitemporal hemianopsia, of which the patient was unaware. At operation a large chromophobe adenoma was found and removed. Seventeen days later the perimetric fields had returned to normal. The patient began to menstruate about six months after operation and when seen five years later was still having normal periods of menstruation, although she had never become pregnant.

Tumors of the cerebellopontine angle are in the majority of cases benign neurofibromas which arise from the eighth nerve. The early symptoms are those of a roaring in the ears which is followed by a loss of hearing. If these tumors are not recognized early, they may grow to a considerable size, compress the cerebellum and produce ataxia and incoordination. By increasing the pres-

sure within the cranial cavity, they may also produce papilledema. The neighboring cranial nerves are frequently involved in advanced cases and facial palsy sometimes develops from involvement of the seventh nerve and numbness of the face and cornea from pressure on the fifth nerve. When these cases are recognized and operation is performed early, these tumors can be removed with relatively little danger and, while the hearing cannot be restored, the other symptoms can be relieved. It is in the advanced cases, in which the tumor has become quite large and has produced signs of increased pressure, that the mortality rate is high and the postoperative results are unsatisfactory.

A case illustrating the advantage of early diagnosis in tumors of the cerebellopontine angle was that of a woman, aged fifty years, who ten months previously had begun to hear a noise as of water in the right ear. Two months later the noise in her ear stopped, but she noticed that she would stagger in walking with a tendency to fall to the right. At the same time she noted numbness of the right side of the tongue, face and head, and four months later found that she was deaf in the right ear. She also complained of a fullness in her head on stooping or coughing.

On examination she was found to be deaf in the right ear. There was partial numbness over the distribution of the right fifth nerve, including anesthesia of the cornea. Lateral nystagmus was noted but there was no papilledema. A diagnosis of acoustic neuroma was made, and suboccipital craniotomy in the upright position made possible the exposure and the removal of a small neurofibroma attached to the right eighth nerve, but which did not involve the seventh nerve. Anesthesia had been produced by pressure on the right fifth nerve. Following operation she had some residual ataxia which gradually cleared up, and two years later she had been completely relieved of all her symptoms except the deafness in the right ear.

In contrast to the foregoing case was one in which the tumor was so large that it could not be entirely removed and an intracapsular enucleation had to be done. The patient was a man, aged fifty-one years, who had been gradually growing deaf for ten years. He had suffered from attacks of dizziness for five years and from unsteadiness in gait for three years. Some diminution of vision and numbness of the right side of the face had developed.

On examination he was found to have horizontal nystagmus, partial anesthesia over the right fifth nerve distribution including the cornea, deafness in the right ear, marked unsteadiness of gait and ataxia and a slight weakness of the right seventh nerve. At operation a large degenerating neurofibroma was found attached to the right eighth nerve. The tumor had become so large that it had compressed the right cerebellar lobe and pons and involved the right seventh nerve. An intracapsular enucleation was done. Following this the patient had a very stormy convalescence and was found to have a facial palsy, and his ataxia and unsteadiness were very disabling. He was seen again after two years, at which time the facial palsy had almost entirely disappeared, there was no evidence of ataxia or incoordination and he was working every day.

The postoperative course in these advanced cases is

sometimes very stormy and the mortality rate is much higher than in those cases in which the diagnosis is made early in the course of the disease.

From the foregoing cases it can be seen that tumors of the brain which are diagnosed early in their development are readily amenable to surgical treatment. This applies not only to the benign, encapsulated tumors, but also to the infiltrating malignant gliomas. However, in the early development of tumors of the brain the symptoms are sometimes so vague and uncertain that a definite diagnosis is impossible. In this event one of two courses is open from the diagnostic standpoint. A patient can be kept under observation until more definite symptoms have developed or encephalography or ventriculography can be carried out. Probably the greatest contribution to the early diagnosis of brain tumors was the injection of air within the intracranial cavity by the lumbar or ventricular routes. These procedures should be carried out only after a very careful general, ophthalmologic, roentgenologic and neurologic examination and should never be considered without a full realization of the risk incurred.

Encephalography or the removal of cerebrospinal fluid and injection of air through the lumbar route should never be undertaken in the presence of increased intracranial pressure as evidenced by choked disks or papilledema. Much emphasis has been laid on the danger of performing lumbar punctures in the presence of increased intracranial pressure, and it is even more hazardous to attempt the removal of fluid from the subarachnoid space and to replace with air. In the presence of increased intracranial pressure, ventriculography, or the removal of cerebrospinal fluid and replacement by air from the lateral ventricles, is the operation of choice. It, also, carries a certain hazard, but this is minimized when craniotomy is performed immediately. Roentgenograms taken following the injection of air through either the lumbar or the ventricular route furnish a great deal of information with regard to intracranial contents. A normal distribution of air in the subarachnoid space, in and around the convolutions of the cortex and within the ventricles rules out the possibility of an intra-



cranial tumor.

At one time all tumors of the glioma group were considered to have the same degree of malignancy and carry the same prognosis. Now it is known that there are certain infiltrating tumors of the brain which, if completely removed with the surrounding tissue, will not recur. Of course these are the tumors which it is important to diagnose early before the lesion has invaded and involved too much of the brain substance. The more malignant types, even if completely removed, tend to recur, but the microscopic examination of these tumors allows for a greater certainty with regard to the prognosis.

The improvement in surgical technic has contributed greatly to lowering the mortality rate and to securing permanent cures in the treatment of tumors of the brain. The introduction of the electrosurgical coagulating and cutting units has allowed much more extensive and radical removal of brain tissue involved by the tumors. Improvements in anesthesia have aided greatly in the management of cases of tumor of the brain, and the various anesthetic agents or combinations of methods of anesthesia allow for greater safety, especially in the operations which require long periods of anesthesia.

While one is more and more impressed with the fact that improvements in technic have been an important factor in lowering the mortality rate and improving the operative results, a comparable factor is the attempt to diagnose and localize tumors of the brain in the earlier phases of their development in order that more radical treatment may be instituted before irreparable damage has taken place in the brain and cranial nerves.

In closing may I again emphasize the influence which ophthalmology has had on the early diagnosis of neurosurgical conditions and how fitting this subject is in paying tribute to your great ophthalmologist, Abner Wellborn Calhoun, who has also earned the well-deserved title of "The Great Physician."

## CORRECTION OF SOME OF NATURE'S MISTAKES BY OPERATIVE INTERVENTION

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Nature at times plays some terrible pranks on the human race, and the cruelty and suffering inflicted on some children by her capriciousness is most distressing. I feel that a surgeon who can correct abnormalities, particularly those which ostracize the pitiful victims from the normal activities of life, is doing a great work indeed. I know of no greater thrill than that of being able to restore a miserable, stinking little girl to her rightful place in her social and psychological spheres.

Some of the patients in the cases described below have been thus restored, and the satisfaction of accomplishing this feat is unexcelled by any surgical experience.

### *Horseshoe Kidney with Bilateral Hydronephrosis*

In horseshoe kidneys, the most common form of renal fusion, the ureters usually enter the kidney pelvis higher up than in non-fused organs and anomalous blood vessels are almost always present. In addition, normal rotation of the kidneys on their vertical axes is prevented by the fusion. The frequency of hydronephrosis in horseshoe kidneys is probably directly connected with these anomalies, which interfere with normal drainage of the kidneys. In the case described below, good drainage was secured by sectioning the isthmus and separating the kidneys, splinting each ureter upon a catheter through a nephrostomy incision, and suspending the kidneys by nephropexy.

W. F., a 11-year-old white boy, was admitted to the Brady Foundation of the New York Hospital on November 24, 1944, complaining chiefly of enuresis. Retrograde and intravenous pyelograms disclosed horseshoe kidney with bilateral hydronephrosis due to obstruction at the ureteropelvic junction.

Two days after admission the left kidney was exposed through the usual lumbar incision. The kidney was separated from the remaining portion of the horseshoe kidney by sectioning the isthmus, hemostasis being secured

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by means of fat held in place with ribbon gut. A nephrostomy, with splinting of the ureter, was then done, followed by a modified Deming nephropexy.

The patient recovered well from this operation, and one month later a plastic operation was done upon the right kidney for the relief of the ureteropelvic obstruction, which was found to be due to the isthmus and the aberrant vessels running to it in the more dependent part of the kidney. By blunt and sharp dissection the isthmus was completely separated from its attachment to the posterior wall of the abdomen. To effect this, the aberrant vessels going to the lower pole had to be severed, great care being taken in separating the kidney from the vena cava and the aorta. By suspending the kidney and splinting the ureter through a nephrostomy wound, it was then possible to relieve the obstruction.

The patient has been cystoscoped and the ureters dilated at two-monthly intervals since the operation. His urine has been clear of pus on practically every occasion, and his general condition has greatly improved. He is growing rapidly and gaining weight. Pyelograms fifteen months after the operation showed a very satisfactory left kidney and only slight hydronephrosis remaining on the right side.

### *Incontinence of Urine Due to Aberrant Ureter*

An aberrant ureter always arises distally to the normal ureter and usually leads to the cranial segment of a double kidney. In the male the ectopic orifice is found most often in the prostatic urethra or seminal vesicle, within sphincteric control. In the female it is usually located in the urethra or vestibule, though it has been found in the vagina or uterus. There is constant seepage of urine. Since the segment of kidney served by the aberrant ureter is almost always functionless, or nearly so, and the ureter itself infected and dilated, the operation of choice is resection of the accessory organ, which usually is buried in the upper pole of the normal kidney on that side.

F. P.,<sup>1</sup> a 23-year-old female, had had constant slight urinary leakage since birth. She had been examined in childhood and told that nothing could be done until adult life. She had always urinated normally and passed normal amounts. One year before her admission to the Brady Foundation, a diagnosis of vesicovaginal fistula had been made and it was for repair of this that she was referred to the author. Examination failed to reveal a fistula.

Cystography and retrograde pyelography were done. A normal bladder with normally placed ureteral orifices was found. Careful examination of the vestibule then disclosed that the purulent discharge evidently came from a point on the urethral floor just within the meatus. A urethral catheter was inserted and a retrograde pyelogram made. This showed the catheter curled up in the greatly dilated distal end of the aberrant ureter. The ureter was moderately dilated throughout its length and extended to a point above the pelvis of the left kidney where a sac-like secondary pelvis was seen. A diagnosis of double kidney with an aplastic segment drained by the ectopic ureter was made, and operation advised.

At operation the accessory segment was found to form the upper pole of a double kidney and to be enclosed within the same capsule. The supernumerary ureter was

posterior and lateral to the normal ureter. It was severed low down and the stump ligated and cauterized. Incising the kidney capsule exposed a shallow groove marking the division between the two segments. The cranial segment received its arterial supply through a branch from the main renal artery. This was clamped, after which the segment (one-sixth of the renal mass) assumed a slightly dusky hue. The venous return was evidently through the normal kidney segment. By sharp dissection through the line of demarcation the accessory kidney was excised, repair being by the fat and ribbon gut technic.

The patient was discharged from the hospital twenty-three days later, with the wound well healed and with her incontinence cured.

### *Postcaval Ureter*

Location of the right ureter behind the vena cava, instead of overlying it, is a very rare anomaly, only 34 cases having been reported, including the one described below.<sup>2</sup> In only five of the cases was corrective surgery—namely, transference of the ureter from its anomalous position behind the vena cava to a more nearly normal site—attempted. In four of these the ureter was divided and anastomosed in its upper end. In the author's case, the duct was severed at the bladder end and reimplanted into the bladder. This would seem the preferable method since the peristaltic wave is not interfered with, and stricture is less likely to occur at the site of repair.

L. P., white, male, aged 44 years, was admitted to the Brady Foundation complaining of pain between the shoulder blades, severe nocturnal headaches, hematuria twice, and intermittent burning on urination. A complete urological investigation, including retrograde and intravenous pyelograms, gave the impression that he had a dead left kidney and a right hydronephrosis with a right-angled kink of the ureter.

The right kidney was exposed and isolated. The ureter, which was greatly dilated, was followed to about 12 cm. below the ureteropelvic junction, where it passed under the vena cava, the dilatation being above this point. Nephrostomy was done and the kidney fixed in position with ribbon gut.

The patient was then placed on his back and the lower end of the wound extended downward and medially. The vena cava was exposed and the ureter identified to it, under it, and passing down across the left iliac vein just before it joined the right to form the vena cava. The lower part of the ureter was isolated and the duct divided at its insertion into the bladder. The ureter was drawn from beneath the vena cava and brought over the vein. The bladder was opened and the ureter reimplanted into its superior-posterior wall. A splinting catheter was inserted into the duct beyond its narrowed point and brought out through the bladder wound. A double suction tube was inserted into the bladder; drains were placed down to the opening in the bladder and the site of reimplantation, and the wound closed in layers.

Postoperatively a tight stricture formed 3 cm. above the bladder reimplantation. Attempts to insert a catheter through the cystoscope proving futile; the bladder was exposed and opened, and a No. 10-F. catheter passed into the ureter after incising its wall at the site of the stricture. The catheter was inserted into the kidney pelvis and out through the urethra, and fixed in place.



Subsequently a discharging sinus necessitated a third operation, when it was found that an abscess had formed about the lower end of the ureter and a considerable portion of the duct had sloughed off. The lower end of the ureter was therefore implanted into the skin.

Following this operation, the patient made an uneventful recovery. The catheter passed to a bag strapped to his leg and he handled this apparatus without difficulty.

### *Exstrophy of the Bladder*

Exstrophy of the bladder is one of the most distressing physical conditions that can assail a human being. The exposed wall of the bladder becomes irritated, and the steady stream of urine issuing from the exposed ureteral orifices bathes all dependent parts and thus far no apparatus has been devised to handle it satisfactorily. Attempts to reconstruct the bladder have usually failed, and the best course ordinarily is to transplant the ureters to the sigmoid—preferably by the following method recently described by Dr. Alfonso Davalos:<sup>3</sup>

With the patient in the Trendelenburg position, a 10-inch transverse incision is made in the suprapubic region and deepened through the rectus abdominis muscle. The ureters are exposed and dissected from the peritoneum for a distance of about 20 cm., the dissection being carried as close to the bladder wall as possible. The ureter is divided at this point.

Usually the right ureter is transplanted first.

The site of anastomosis in the rectosigmoid is next selected. The best location is the anterior aspect in the median line, avoiding the regions covered with mesenteric circulation. It is necessary at this point to measure carefully to make certain that the ureter reaches the intestine without either undue tension or laxness.

A transverse incision 4.5 cm. long is made in the sigmoid, cutting through the serosa and muscularis and exposing the submucosa for a distance of 3 cm. A small incision is then made in the upper border of the wound to form a trough.

The cut end of the ureter is implanted in the exposed submucosa. The edges of the trough are closed over the ureter with two interrupted sutures of fine silk. Mattress sutures are then placed in the wound to draw the lower edge of the incision over the ureters.

A transverse incision 3 cm. long is next made through the submucosa and mucosa, as close as possible to the lower border of the intestinal wound, to allow the flap of the mucosa and the ureter to enter the bowel. The mattress sutures are tied, drawing together the edges of the wound and inverting the serosa and muscularis. One additional interrupted suture is placed between the mattress sutures to reinforce the closure.

The transplantation being now completed, the transplanted area is covered with the posterior reflexion of the ureter where the ureter was situated, using several interrupted sutures of fine silk. The operative area is thus extraperitonealized and the sigmoid is fixed in the correct position.

An identical procedure is done on the opposite side.

The wound is closed in layers with interrupted sutures of chromic catgut No. 1, and the skin with interrupted sutures of fine black silk.

E. L., a 9-year-old Negro girl, was admitted to the Brady Foundation of the New York Hospital, on November 11, 1932, complaining of a mass in the bladder region which dripped urine continuously.

Examination revealed complete exstrophy of the bladder. The trigone was plainly visible and there was no semblance of a urethra.

On the day of admission, her right ureter was transplanted into the sigmoid, using a modified Coffey technic. Convalescence was rather slow, but four months later she had improved to such an extent that the left ureter was transplanted into the sigmoid.

Five weeks later, the exstrophied bladder was excised, and she was discharged on June 10, 1933 (seven months after admission) with all wounds healed and in excellent condition.

This patient, now a young woman of 23 years and about to get married, has been seen at quite frequent intervals, including a recent checkup. She is, and has been in the interim, in excellent health.

### *Two Cases of Human Cloaca*

Two most unusual patients—both young girls with persistent cloacas—were operated upon by the author and cured. In the first case the rectum opened into the vaginal vestibule. The ureters emptied into a continent bladder, but there was overflow incontinence as the bladder was without sensation and entirely untrained. Feces and urine were mixed in the vestibule, which was covered at birth and was opened with two stab wounds, through which the excretions exuded constantly.

In the second case, the rectum opened into the vestibule and was continent, but

the ureter from the patient's single kidney was aberrant and opened in the upper wall of the vagina, and was incontinent.

The plight of these little girls was pitiful, indeed. Because of the stench which accompanied their condition, they were unable to attend school and were completely ostracized from normal friendships and activities. Irritability, dejection, and fear marked them.

These cases are described briefly below.

M. P., white, female, 9 years old, entered the hospital on June 14, 1938, with a congenital deformity in the form of a persistent cloaca and inability to control evacuation from this cloaca. There had been an appendectomy and a colostomy for obstruction but no operation on the cloaca. The surgeon reported that he had found normal female pelvic organs.

Physical examination showed separation of the recti muscles so as to form an inverted V with a separated pubes as the base. A soft mass, the bladder, filled this V. The pubes were separated 7 cm. with a fibrous band across the separation. A bifid clitoris lay between the anterior ends of the two widely separated labia majora. No urethral, vaginal, or anal orifice was found. In the space between the labia were two openings, 1 cm. in diameter and 2 cm. apart, from which exuded a mixture of urine and feces. There was no sphincteric action to either opening.

Excretory urograms showed a normal upper urinary tract, but both pyelograms and cystoscopy failed to disclose the location of the distal ends of the ureters. It was concluded that the cystoscope, inserted through the lateral fistulous tracts, apparently entered the uterine cavity and not the bladder. Gastrointestinal x-rays showed a normal stomach and duodenum, with tremendous dilatation of what appeared to be the rectum.

One month after admission, a plastic operation to create an artificial anus was done. A perineal incision was made in the region where the anus should be and carried down to the pelvic floor, disclosing excellent levator ani muscles and a dimple surrounded by a fairly good sphincter muscle. A loop of the rectum was drawn through this opening and sutured so that it protruded outside. Five days later this protruding loop was opened with a coagulating current and a large catheter inserted. For two weeks this artificial anus was dilated and irrigated daily.

Eighteen days later an exploratory operation was done with the object of closing the lateral fistulae. An incision was made from one fistulous opening to the other, opening wide the cloacal pouch. A cervix was found on its upper portion, and a fairly normal urethral opening in the lower anterior midline, at the skin margin. A sound passed through the latter entered the bladder, releasing urine. The rectal opening was next to the skin margin in the posterior midline of the cloaca, and was 2 cm. in diameter. The mucous membrane about the rectal fistula was incised and dissected down to the rectum, and closed with silver wire. A rectal tube was left in the artificial anus.

The patient was unable to tell when her bladder was distended, but she was taught to empty it regularly by pressure over the symphysis and thus was continent and no longer wet the bed. The wound gradually healed and the rectum was dilated daily until she was able to be up and about, with control of feces. She was discharged eighty days after admission, her mother having been taught to keep the rectum dilated by means of a large rectal tube.

Contact was kept with this patient for several years, during which she had good urinary and fecal control,

made excellent grades in school, and participated in the usual activities of a girl of her age. Then, for a period of about a year, her rectum was not dilated and there developed a fistula into the vagina, at the site of the original one. Consequently, in July, 1945 (seven years after the original operation), she was operated upon again, for closure of this fistula. Thereafter she was taught to dilate her own rectum, and since then has had no further difficulty.

M. D., white, female, 7 years old, was admitted to the Brady Foundation on March 23, 1945, for the relief of urinary incontinence.

Since birth she had passed urine and feces through a common opening; there appeared to be no rectum; she dribbled urine constantly but seemed to have fecal control.

Physical examination showed no evidence of an anal orifice. The vaginal opening was unusually wide and urine dribbled from it constantly. Excretory urograms gave the impression of a marked hydronephrosis of a single kidney (right) with dilatation of the ureter.

Further examination under drop ether anesthesia showed a very relaxed but normally situated urethra and a vagina of the usual depth. The rectum opened into the vestibule, just below the vaginal orifice. Cystoscopy was done without difficulty, but no ureteral orifice was found; nor was a ureteral orifice discovered in the vestibule, urethra, or rectum, which were cystoscoped. Indigo-carmin injected intravenously appeared through the vagina. Through the vaginoscope, bladder tissue was observed on the roof of the vagina and an orifice was seen but could not be catheterized.

Twelve days after admission, the aberrant ureter from the patient's solitary kidney was transplanted into the bladder, which was found to be very small. Exposure showed the ureter to be greatly thickened and enlarged. It was dissected down as near as possible to its union with the vagina and transplanted to the posterior wall of the bladder. A No. 14-F. catheter was attached to the interior of the bladder and its other end passed from the bladder through the urethra in order to afford the patient good urinary drainage.

During convalescence from this operation the patient was taught urinary control, and in two weeks was voiding increasing amounts and at three to four-hour intervals.

Three weeks after the first operation, a plastic operation was done to transplant the rectum from the vestibule into the perineum. A 3 cm. incision was made just above the end of the coccyx, and with a Kelly clamp the tissues were separated down to the muscle of the perineum, the fibers of which were then separated carefully. An incision was next made around the rectal opening into the vaginal vestibule, extended down, and the rectum separated from the vestibule for about 10 cm. A clamp was inserted through the area in which the rectum was lying freely. By means of forceps the anus was drawn through the perineal incision. Four ribbon-gut sutures were fixed to the wall of the rectum and the musculature of the perineum and tied, anchoring the rectum in position. The cut edges of the anus were sutured to the edges of the skin by a running suture of chromic catgut. The incision in the vestibule was then closed, with a Penrose drain extending down about the rectum. A No. 20-F. catheter was fixed in position in the rectum and left there until she had her first bowel movement (five days later).

She was discharged from the hospital five months after admission.

The results in this case have been excellent. The patient now has complete continence of urine and feces; her bladder has become distended so that she holds the normal amount for a child of her age; and she attends school regularly.

### *Summary and Conclusion*

In conclusion it may be stated that our modern methods of surgery may be effective



tive in restoring almost any physically defective person to normalcy, and the satisfaction of producing a normal human being who may enjoy all the rights and privileges of social, scholastic, and economic livelihood is great indeed.

In fact, there is nothing in my whole life that has rewarded me so greatly as relieving the four above-described girls of their infirmities. Each of them had attempted to attend school and had been driven home in tears by some schoolmate calling her "Stinky" or some such cruel name. Three of them learned to read and write in our wards at the New York Hospital. Each, after repair, returned to school and rapidly caught up with children of her own age group. All participated in social life, and one is married and another has definite prospects.

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#### THE MEDICAL PRACTICE OF

DR. W. B. FREEMAN

*Carnesville, Georgia, 1823-1826*

JOSEPH KRAFKA, JR., M.D.

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Augusta*

The library of the University of Georgia School of Medicine has recently been presented with the account book of Dr. W. B. Freeman by A. A. Rogers, Jr., found among materials stored in a warehouse at Mountain City, Ga. This old record contains daily entries in the medical practice of this physician and gives a fairly clear picture of the diseases he encountered and the methods of treatment in the back country during the years 1823 to 1826.

Nothing is available as to his training. His name does not occur in our roster of graduates from the Philadelphia or New York schools for the 1800 period. Schools had not as yet been established in the South. It is highly probable that he came up under the preceptor system. His account book

shows that he himself had an understudy.

That the man was well trained for his day is indicated by the extent of his armamentarium, which includes the use of eighty-four drugs. From the prescriptions recorded it is at once evident that the diseases with which he had to deal were mainly fevers, dysentery, intestinal parasites, gonorrhea, gastrointestinal disturbances and pneumonia. Infection of the eyes was frequent. He was also called upon to extract teeth, to lance abscesses, to suture cuts and to set broken bones. There is no definite entry that shows positively that he practiced obstetrics but it is difficult to believe that he would have left this to midwives.

His prescriptions include the following entries:

Tinctura ferri muriatis  
Tinctura guaiaci  
Tinctura hydrargi  
Tinctura rhubarbari  
Tinctura myrrh  
Tinctura lytton  
Tinctura thebias  
Gutta diaphoretica anodyn et carminitiv  
Bateman's drops  
Pll. oppi meritt riperi oxymurii hydr.  
Pv. pyialis diaphr.  
Pv. diuret.  
Pv. escharot.  
Pv. stypticus chiv.  
Pv. melor vesicant.  
Pv. cinchona  
Dovers powders  
Unguentum basilicon flavum  
Unguentum citricum  
Unguentum mer. fort.  
Sulphat. zincii  
Rubigo ferri  
Arsenicum album  
Carbon. potass.  
Carbon. ferri  
Acetis plumbi  
Sulphas cupri  
Carbon. ammonii  
Acid sulph. dil.  
Sulph mag.  
Acid muriatis.  
Acid nitric  
Acid vitr. dil.  
"Rheum palmatum"  
Emit et alb. cinnamoni  
Cretaceous jalap  
Spirits of nitre  
Boric soda  
Calomel  
Powdered cream of tartar  
Liquorica  
Sarsaparilla  
Jalap  
Aqua oris  
Sacharum saturni  
Paregoric eliscis  
Quatum vomitorius  
Gum asafetida  
Polygala senega

Potassium antihemorrhagicum  
Pv. antinoni crud.  
Antimoni tartrate

### Non-specifics used were:

Vermifuge cathartic  
Antispasmodic portio  
Gargarismus  
Hydrag. cathartic  
Expectorant preparation  
Tonic preparation  
Ol. caryoph.

In four instances he prescribed a collyrium for the eyes. There is one record of the use of British oil. Tincture of digitalis was used on four patients, several times repeated. Eth. sulph. appears twice, evidently an abbreviation for sulphuric ether, used as drops.

His method may be followed through on one patient from Sept. 30 to Oct. 26, the only case recorded with a fatal termination. I include the entire account:

Sept. 30th	Venesection	.50
	Fol. senna	.13½
Oct. 3rd	Febrifuge	1.00
	Ipecac comp.	.25
Oct. 6th	Visit and advice	1.00
	Venesection	1.50
	Pulvo febrifug.	1.00
Oct. 7th	Pulvo cinchon.	.75
Oct. 8th	Visit et px. rhei	1.2
Oct. 10th	Visit et advice	1.00
Oct. 11th	Visit at night	2.00
Oct. 12th	Emplastrum epipast No. 4	2.00
	Ung. mer. fort	.
	Pv. col. julip pili opii	.25
	Attention night	2.00
	Cathartic comp.	.37½
Oct. 13th	To visit night and advice	
	Pv. stimulant et diaph cp.	1.00
	Colombo cum serp. virg	.50
Oct. 14th	Visit in noct. (rising from bed) cathartic	.25
Oct. 15th	To visit noct.	
Oct. 16th	To visit noct.	
Oct. 17th	To visit noct.	
Oct. 18th	To visit noct. (rising from bed)	
Oct. 19th	To visit noct. (rising from bed)	
	Pv. stypt.	.25
	Sulph mag.	.50
	Visit in die cathartic	.25
	Pulv. febrifug.	.50
	Tinct. digitalis	.37½
	Renewing and applying emplastron	
Oct. 20th	To visit noct.	
	Pv. stimulant et diaphor.	1.00
Oct. 21st	Applying and renewing emplastron	
Oct. 22nd	Visit noct.	
	Val. julep.	1.00
Oct. 23rd	Vst. No. 4 pro advice	
	Pulv stim et diaphr. chv.	1.00
	Emplastrum (extra large)	
Oct. 25th	Vst. No. 3	
	Pulv. cinchon.	.75
	Acid muriat.	.37½
	Pulv. stim. et diaph.	1.00
	Gargarism	.25
	Val. julep	1.00
	Cath.	.25
	Vst. No. 5	
	Eth. Sulph. et phl.	.75
Died Oct. 26th.		

The system of venesection, sweating, blistering and plaster was his main technic in quite a number of cases. The plasters must have been of the wax variety, since he "renew" them, i.e., remelted them. Seasonal appearance of malaria is evident as shown by his records of prescribing cinchona. Children were invariably treated by fever medicines, cathartics and vermifuges, while the women patients were for the most part subject to gastrointestinal upsets. When cathartics failed he frequently resorted to glyster. One record shows a charge of \$3.12½ for "Preparing a glyster et attention from 5 in die, 5½ in noct." He provided the patient with an enema pipe at the cost of 37½ cents.

Only once does the record show the application of leeches. There is one sale of "sulphur cups".

His surgery was negligible. There are two accounts of the opening of abscesses. He records "taking three sutures in the lip and cheek—dressing same with ung. basil. \$3.25." He also opened an abscess on the scrotum for an individual suffering from gonorrhea. There is one account of an "operation on thumb". He treated a superficial ulcer with "creeping vesicated surface #5". He charged a patient \$5 for extirpating two fungous excrescences from the eye.

He had fourteen male patients under whose names appear the following record:

Balsam of copaiva	\$1.25
Sod. sulph.	.25
Pv. astrigent	.50
P. P. syringe	.50

One individual had a refill of the prescription for copaiva eight times from March 18th to Jan. 10th, evidently without effecting a cure.

There is one account of the sale of balsam of copaiva \$1.12 and a female syringe \$1.75, and one account of "making examination of lady per vaginum" and leaving an F.F. syringe and an enema pipe at a charge of \$9.00.

In order to secure a picture of the extent of his practice the number of patients seen during the year 1826 was determined. He had 125 running accounts. During the year he made 500 calls. The maximum number for any one patient was 26. Fifty-five of the patients seen were children and 30 calls were for the "lady"; 16 for tenants; 3 for "father", and 2 for "mother".



Twenty-three calls were made for thirteen planters to attend their Negro slaves. The charges for slaves were generally less than those for the masters, although this again depended upon the distance traveled in making the call. The following charge illustrates the point:

Capt. Robert C.	Dr.
Visit to negro boy	\$9.00
Febrifuge	.50
Cathartic	.25
Lapis castil	.25
Ung. basil	.25
Visit to Sister Polly	15.00

The illnesses among the Negroes were for the most part periodic fever as shown by the number of times cinchona is administered. He did, however, use an em-plastron on a Negro boy, set a broken jaw for a Negro man and made an examination per vaginum on a Negro woman.

To the practitioner of today the number of calls recorded above are few. But if one considers the distance traveled and the mode of transportation, it is at once apparent that the doctor was a busy man. He was called to Clarkesville, a distance of about 30 miles, to attend the wounds of a local captain. The charge was \$25.00. He was called to a plantation at Pendleton, S. C., a distance of 43 miles, to treat a Negro woman. His practice carried him to Franklin Springs, and to Habersham. He must have had a very good reputation, because he was called to Athens to treat the son of a prominent widow. The distance is about 28 miles; the charge on the first trip \$9.00; on the second trip, where he was in attendance from 4 until 12, \$15.00. This is rather unusual because there were several doctors with statewide reputations in Athens at the time.

His mode of travel is established by one entry which shows that he bought a new gig in Augusta at a cost of \$175. He also credits one of his patients with the price of a new surcingle; another with a bridle. He got \$2.00 for a buggy whip when he made his trade for the gig.

The average charge for country trips was \$1 per mile; double at night. He adjusted these charges when he could travel from one plantation to another, as his records show. On his long trips invariably some one would call on him for an "advice script". The country people may have tried to take advantage of him during the "camp

meeting" time, but he charged for all "advice script" given. He collected a few bills while in attendance at camp meeting.

The total amount set down in his books for the year 1823 (not the total collected) is \$1010.49. The maximum charge during the year was \$25.00; the minimum 12½ cents. How much of this was cash transaction it is difficult to say. Some patients "gave their note". He credits one patient with \$2.00 for hauling two loads of wood sixteen miles with cart and ox. He credits another with \$1.00 for a bushel of corn. Another man got credit for two chairs on a bill of \$1.50. Mrs. MacM. received \$1.00 cash for making a homespun vest and two pairs of homespun pantaloons. He credited the account of Gen. B. C. with 50 cents for a tavern bill. He took in one load of shucks at \$1.00; 600 lbs. fodder at 75 cents a hundred; 2½ bushels of wheat at \$2.50; 798 pounds of pork at \$39.90. One man built a bridge over a gulley in payment of his account. He also received tobacco, corn, sweet potatoes and doubtless many other presents which he did not make a matter of account.

He depended on Augusta for supplies. He bought a box of medicines, two bushels of salt, one New Testament (68½ cents). He mentions balance due on postage on the Georgia Journal. After he bought his new gig, he had to send to Augusta again to buy a carriage wrench.

Cash was not always available and change was sometimes impossible to make. He carried a credit of 50 cents for several months on an account where a five dollar bill was involved. He was paid on one occasion with a five dollar bill which had been defaced and had a counterfeit signature of the President's name on it. He notes in his record that the bill is no doubt genuine and drawn on the Planter's Bank in Savannah.

He frequently had difficulty in paying postage on letters delivered by the post boy, who incidentally was one of his balsam of copaiva patients.

He seems, however, to have been perfectly honest with his patients, since he would credit them with unused medicines, with pill boxes or even with the return of their p.p. syringes.

There is one more entry that is of interest, as of Jan. 22, 1826, to assuming the payment of 11 dollars for Capt. Sasmuth, State Coroner—pro Negro woman—attending as witness on Inquisition of the Negro woman from Sunday night till Tuesday following.

## BENIGN PAPILLOMA OF THE URETER

ERNEST FELBER, M. D.  
*Atlanta*

Tumors of the ureter are rather rare and benign tumors are less frequently observed than malignant ones. The diagnosis of ureteral tumors is often difficult, but nevertheless it does not seem that too many cases have been overlooked, because ureteral tumors are also rarely encountered at autopsies. The progress urologic diagnostic methods have made in recent years is clearly shown by the more frequent preoperative diagnosis of ureteral tumors.

There are no symptoms characteristic for ureteral tumors only; all the symptoms may as well be attributed to various lesions of the ureter or kidney.

To establish the diagnosis of ureteral papilloma is easy, if the ureteral tumor is seen cystoscopically protruding from the ureteral orifice into the bladder, an incident which was encountered in many cases reported in the literature, but otherwise the diagnosis rests upon the demonstration of a filling defect in the ureter by an ureterogram.

Melicow and Findley reviewed the literature and reported 29 cases of benign papilloma of the ureter up to 1932. Among those 29 cases 36 per cent were diagnosed preoperatively, but none by ureterogram.

Rusche and Bacon added eleven cases up to 1938, but three of them were diagnosed by ureterogram. Cooney reported a fibroma of the ureter in 1942.

Ramsey reported one case in 1939 found at necropsy. So far I have found in the literature 46 cases and the case we wish to report being the forty-seventh, whereas 182 cases of carcinoma of the ureter have been reported. It is noteworthy that between 1932 and 1942, five cases out of thirteen

have been diagnosed preoperatively by ureterogram as compared with none in the series of 29 cases reported by Findley and Melicow in 1932. This fact demonstrates very well the progress in urologic diagnostic methods. The reason for the difficulties in the diagnosis lies partly in the omission to make a complete ureterogram and partly in the fact that it may be extremely difficult or almost impossible to inject opaque media by means of ureteral catheter into the ureter to outline the ureter in its entire length in the presence of an obstructive lesion. The difficulties are many-fold; in some cases even the smallest caliber ureteral catheter is unable to pass by the obstruction in the ureter and the opaque media enters perhaps the part of the ureter below the obstruction only and the film does not reveal the outline of the ureter above the obstruction. There is also the possibility that the injected opaque media after meeting the obstruction is returning to the bladder too quickly to be seen on the film. In other cases the ureteral catheter introduced into the kidney pelvis permits just the filling of the ureter above the obstruction and nothing can be seen on the x-ray film regarding the part of the ureter below the obstruction.

Rusche and Bacon advocate for the latter cases a small caliber ureteral catheter and withdrawing it a few centimeters at a time from the pelvis to the bladder, and taking a series of x-ray pictures on the way down to get a complete ureterogram. They claim that they have not found this method described in the literature and I agree in the usefulness of the method to visualize the ureter, but I do believe that this method has been used by many urologists in cases where a pyelogram was made and no opaque media entered the ureter. It seems to me more difficult to get a ureterogram without the possibility to pass an ureteral catheter above the obstructing tumor. This condition was present in our case. The ureteral catheter met an obstruction about 14 cm. above the ureteral orifice, that could not be by-passed on several attempts. I injected hippuran solution and the first film showed the catheter and one well outlined dilated kidney calix; nothing was seen in the ureter. I injected again 10 cc. of hip-



puran solution and on the second film some more dilated calices appeared but no filling in the ureter. It was clear that a part of the hippuran solution by-passed the obstruction in the ureter, thus filling the calices and another part of the solution returned to the bladder very quickly after meeting the obstruction, and the picture taken one or two minutes after the injection of the opaque media could not reveal any filling in the ureter.

The next film was made during the injection of the opaque media into the ureteral catheter and brought about the desired ureterogram. The film shows a normal-shaped and sized ureter for about 14 cm. above the ureteral orifice so far as the catheter had been introduced into the ureter and above the catheter a filling defect with regular outline, the ureter above the filling defect as well as the kidney pelvis and calices markedly dilated. Taking the picture while injecting opaque media did not give the injected solution below the obstruction the opportunity to return to the bladder. It took three injections of 8 to 10 cc. each to get sufficient opaque media above the obstruction, because the obstructed lumen of the ureter permitted just a small amount of hippuran to pass by. The injection of opaque media has to be done very cautiously and without force to prevent overdistention and damage to the ureter; and for this reason I prefer repeated injections of rather small amounts of opaque media and taking a series of pictures to one injection of a large amount, if the first film proves to be unsatisfactory.

It is obvious that a very thorough investigation performed with great patience and adapted to the variety of every single case is necessary to diagnose a ureteral tumor.

The value of excretory urography in the diagnosis of ureteral tumors is limited, and I do not think that a conclusive diagnosis can be made solely on the findings of excretory urography, but the usefulness of the method is based on the fact that excretory urograms will certainly show some pathologic changes in the kidney and ureter, like dilation of the ureter, pelvis, or the calices, requiring further investigation. In cases with symptoms pertaining to the up-

per urinary tract excretory urography is commonly used by the urologist and non-urologist to find out whether any pathologic changes are present.

Encountered disease may induce the urologist to more investigations in a certain direction and the non-urologist to refer the patient to a competent specialist. Study of the films obtained by excretory urography in my case revealed definite dilation of the pelvis, the calices and the upper third of the ureter and no filling of the lower two-thirds of the ureter, thus indicating some disease in the kidney and ureter, and, although not revealing the cause of same, showing the possibility of an obstructive lesion below the dilated ureter. The dilations in my case evidenced also that the dilations found on retrograde pyelography are not caused by overdistention as one may suspect by repeated injections of opaque media, but are the product of the existing pathologic condition, which demonstrates again the usefulness of excretory urography. It is my opinion that retrograde ureteropyelography and excretory urography supplement each other to the accomplishment of a correct diagnosis in ureteral tumor. This is particularly true for those tumors where we have to rely entirely on x-ray findings and where cystoscopy or symptoms, like hematuria, may not direct our thoughts toward a tumor condition.

It is generally agreed that the demonstration of a filling defect is the pathognomonic sign of ureteral tumor, but there are symptoms in many cases which are highly indicative for ureteral tumor. Hematuria is present in about 70 per cent and if ascertained by cystoscopy that the bleeding comes from a tumor protruding from the ureteral orifice, the diagnosis is secured. Continuous bleeding from the ureteral orifice whereby the blood is eliminated without the usual vigor is very suspicious for a tumor in the lower part of the ureter.

Meeting an obstruction in the ureter by means of an ureteral catheter and obtaining bleeding through the ureteral orifice on attempts to by-pass the obstruction is also a probable sign of ureteral tumors.

All the signs are recorded in the litera-

ture and described by Rusche and Bacon. The signs are not different in benign and malignant tumors except that a regular outline of the filling defect indicates benign tumor and an irregular outline indicates a malignant one, but one should not be too definite in the evaluation of this sign because one never can be sure that the opaque media was distributed in the ureter in a way to exclude an error. The history of the case and its general condition is also to be taken into consideration; severe secondary anemia is encountered in benign and malignant bleeding cases. The final decision rests with the pathologist. Since the treatment of choice is ureteronephrectomy for both benign and malignant tumors the preoperative differentiation is not too important.

The necessity to reach a conclusive diagnosis, to plan and institute the proper treatment at once and also the fact that but a few cases have been diagnosed preoperatively, justifies the broader discussion of diagnostic methods, before the case is reported.

This specimen is the left kidney and the left ureter, removed on September 25, 1941, at St. Joseph's Infirmary, Atlanta. The patient, a female 58 years old, gave a history of recurrent attacks of pyelitis since April, 1941, which means pus in the urine, fever and slight pain in the left kidney region. The attacks lasted three to four days and were successfully treated with sulfathiazole, insofar that the urine became clear and free of pus and the fever and pain subsided, but she did not feel very well and had possibly slightly elevated temperature between attacks. The temperature on several days was between 99 and 100 degrees F. I first saw the patient on August 8, 1941, during an attack of fever. The urine was cloudy, the sediment showed numerous pus cells, and streptococci, but no red blood cells. The cystoscopic examination revealed a normal bladder, pus in the urine from the left kidney and 15 cc. residual urine in the left kidney pelvis. Indigocarmine was excreted in three minutes from the right kidney, and in five minutes from the left kidney. The x-ray of the kidneys showed no evidence of stones, the left kidney being somewhat lower than the right. An excretory urogram showed a normal right kidney, but dilated calices and pelvis of the left kidney. The left ureter could not be seen. The urogram did not reveal the cause of the dilation of the calices and the left kidney pelvis, therefore retrograde pyelography was performed. The retrograde ureterogram showed the above-mentioned filling defect, which led to the diagnosis of ureteral tumor.

Consequently, I decided to perform a nephroureterectomy as the operation of choice for ureteral benign or malignant tumors. We exposed the left kidney and the upper part of the left ureter and felt a soft mass in the finger-sized dilated upper third of the ureter; the ureter below the tumor was normal. We removed the kidney and the ureter down to the bladder.

The convalescence was uneventful, and the patient was dismissed on the tenth postoperative day.

The report of the pathologist, Dr. John Funke, was: primary benign papillary tumor of the left ureter.

## Conclusions

This case seems to be remarkable for four reasons:

1. No hematuria, which is encountered in 70 per cent of the reported cases.
2. This case again shows that every unilateral kidney infection requires exact and complete urologic study.
3. Excretory urography alone is of no value in the diagnosis of ureteral tumors.
4. Sulfathiazole is a powerful urinary disinfectant in the presence of an obstructive lesion also, but its curative effect on the urinary infection does not exclude serious conditions in the urinary tract requiring surgery.

I felt that this rare case may be of interest particularly because it is the first case ever reported in Georgia.

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## SKIN GRAFTING IN HEMOPHILIA

Two Boston physicians—Charles S. Davidson and Stanley M. Levenson—report a successful skin graft operation on a patient with hemophilia in the June 30 issue of *The Journal of the American Medical Association*. They controlled the bleeding by applying a mixture of powdered sulfanilamide and thrombin, the enzyme which is responsible for the coagulation of the blood.

## THREE MILLION BABIES BORN IN U. S. DURING 1945

The more than three million babies born in the United States in 1945 reflect the continuing increase in the birth rate for the past several years. It is estimated that between 1933 and 1943 the birth rate increased 30 per cent, according to an editorial in the May 18 issue of *The Journal of the American Medical Association*.

Continuing the editorial says:

"This does not mean that the average American family is growing larger. The principal explanation for the increase appears to be the rise in the marriage rate and the increase of one and two child families. This is deducted from the analysis of the increase in the first, second, third and fourth or higher births in the family. Thus, during the war years 1941 to 1943 the birth rate for all women in the reproductive age increased 22 per cent: first births increased 21 per cent, second births 31 per cent, third births 27 per cent and fourth births 19.5 per cent."



## PRESIDENT'S PAGE

### LABOR AND MEDICINE

The present conflict between organized labor and management seems to have a severe political background; in fact, the background is the same as that which is reaching out to force medicine under government or state control.

The basic body behind both movements is the International Labor Congress, a labor body financed by funds from some twenty or more governing bodies, of which the United States is one. When this international body was first set up it was supposed to be a fact-finding organization to gather the data concerning possible improvement in the status of labor on a world-wide scale, which could then be presented to the legislative bodies of the various members to guide the formulation of their programs. However, with the passage of years, the ILC has taken upon themselves not only to gather facts, but has drawn up the legislation in the form in which they desire it and then have spent large sums in lobbying for its passage.

The present Wagner-Murray-Dingell bill is identical with the suggested bill drawn up in the Paris meeting of the ILC. Thus

at the present time the Congress of the United States is being asked to invoke a law on the people of this country which had its origin in the minds of foreign thinkers, who want to see their views fostered upon us in order that our economy is forced to the same level as that existing in the domain of the other members of their organization. While this may result in raising the economic level of labor in other countries, it will amount to a lowering of the standard in this country.

Apparently the ILC is working through the CIO in hope of fomenting strikes to such an extent that the government will have to take over industry, and then the CIO will form a political party which may be able to control the government, under which circumstances the CIO will be government employing CIO in industry and socialism will be forced on the rest of us, because each and all of us will have no employer save the CIO controlled government.

Socialism is, in basic analysis, government controlled industry and labor, or industry and labor working for a government controlled by a dominant political party.

RALPH H. CHANEY, M.D.

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## ASSOCIATED MEDICAL CARE PLANS SHOW MEMBERSHIP EXPANSION

Voluntary medical care plans in nine states have been admitted so far to membership in Associated Medical Care Plans, a new national nonprofit organization which will include all state and local medical care plans that comply with the minimum standards approved by the Council on Medical Service and Public Relations of the American Medical Association.

According to the May 18 issue of *The Journal of the American Medical Association*, the nine plans which have been tentatively approved as meeting the standards of the Council are: California Physicians' Service, Iowa Medical Service, Michigan Medical Service, Ohio Medical Indemnity, Oregon Physicians' Service, Medical Service Association of Pennsylvania, Medical-Surgical Plan of New Jersey, Nebraska Surgical Plan and Surgical Care, Inc., of Kansas City, Missouri.

The nine applications will be formally presented for acceptance at the May 17 meeting of the Council, and additional applications will be considered at the June 28 meeting.

*The Journal* says that Council members are busy preparing an interpretation of the "Standards of Approval" as they will be used in granting the "Seal of Acceptance." Under certain conditions, the Council will grant the right to print its seal on all official papers of accepted plans and on any promotional literature or display material used by these plans.

"Suggestions as to the type of seal that might be used have been received from various sources," *The Journal* says, "and will be acted on by the executive committee of the Council this month. The favorite to date is a shield outlined in blue, with a caduceus in the center." Continuing, *The Journal* says in part:

"Thirty-one states now have voluntary prepayment medical care plans. These are Alabama, California, Colorado, Connecticut, Delaware, Florida, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, West Virginia and Wisconsin.

"Seventy-three plans are included in the 31 states named. However, for tabulation purposes the 20 Washington state bureaus and the five

Oregon plans might better be set forth as two statewide plans, thus reducing the quoted total to 51 plans. Twenty-three states have only one plan, in most cases statewide. Four states have two plans each, a statewide plus a local plan, or two plans dividing the state. Three states have three plans. One state has five plans and one state has six plans. Thirty-four of the plans operate in coordination with Blue Cross Plans.

"The 10 medical plans launched in 1945 are the Alabama Hospital Service Association (by rider), Iowa Medical Service, Hospital Service of New Orleans (by rider), Missouri Medical Service (St. Louis), Nebraska Surgical Plan, Central New York Medical Plan, Inc. (Syracuse), Medical Mutual of Cleveland, Oklahoma Physicians' Service, Group Medical & Surgical Service (Dallas, Texas) and Surgical Care, Inc. (Roanoke, Va.).

"The 10 plans that have been set up thus far in 1946 are Connecticut Medical Service, Florida Medical Service Corp., Mutual Medical Service, Inc., of Indiana, Kansas Physicians' Service, Montana Physicians' Service, New Mexico Physicians' Service, Northeastern New York Medical Service, Inc., Albany, Ohio Medical Association, Inc., and the Wisconsin State Association Plan

"In eight additional states and the District of Columbia plans are in process of formation: Arizona, Idaho, Illinois, Maine, Maryland, Minnesota, Rhode Island and Wyoming."

## VETERANS' ADMINISTRATION POSITIONS

Opportunities for careers in the Veterans Administration's new department of medicine and surgery were discussed at the annual meeting of the Medical Association of Georgia in Macon, by Dr. Frank B. Brewer, VA medical director for the Southeast.

Dr. Brewer told the physicians who attended the meeting that the pay is attractively placed at sums comparable to that of doctors in the armed forces, in rank from First Lieutenant to Brigadier-General.

Recognition of professional skill brings a 25 per cent addition in pay for those doctors in VA who have specialty board rating, so that a physician's top pay may reach \$11,000 annually, Dr. Brewer said.

He added that generous leave provision is made and leave is encouraged for the beneficial effects rest has.

Practice of medicine with the entire resources of the federal government, including all modern equipment and latest drugs and medicines, and the opportunity to study innumerable types of cases and become specialists in chosen fields also were listed by Dr. Brewer as reasons why the VA offers a medical career that is worth while.



## GREETINGS, DOCTOR

I am back home—in Donalsonville—with the hope of again enjoying life, liberty and the pursuit of happiness.

With this announcement I add my thanks to the doctors who remained at home and did a good job while those in the armed services were doing likewise.

A few observations which I hope you will read are listed below. First, close contact with young medical officers from every section of the country has convinced me that our medical schools and hospitals are doing an increasingly better job of training doctors. From the wartime publicity given the Army and Navy medical departments, the public is inclined to assume that the achievements of these departments have been due to the training given to medical officers in Army and Navy medical installations, but it has been clearly evident that the high quality of service rendered by medical officers has been almost entirely due to the fine training received by these doctors before entering upon military service. It is important that the medical profession and the public realize that medical services for the armed forces were rendered by civilian doctors in uniform.

A second observation has been the uniformity of training of doctors. Whether reporting for duty from the large metropolitan centers, the woods of Maine or from the bayous of Louisiana, it has been noted that no section of the country has a monopoly on brains and that well trained doctors may come from any school or any section of the country.

A third observation, as we struggle toward a return to normalcy is the present trend toward a better distribution of doctors. In spite of the efforts of various organizations, both lay and professional, to secure equitable professional services for the rural sections, little progress had been noted prior to the start of demobilization of the armed forces. Now, many doctors returning to their former metropolitan locations are finding no offices, no equipment and no homes. As a result, many are locating in smaller towns and cities who, otherwise, would be struggling to become established or re-established in larger cities.

A fourth observation has been the increased appreciation by the profession of organized medicine. It is of paramount importance that doctors become actively affiliated with their county, state and national medical organizations. While it is agreed that differences of opinions will arise and exist as to adopted policies of our medical associations, it should not be forgotten that these policies are adopted in a democratic manner and that organized medicine will best represent the majority interest only if the majority exercises its rights in using its votes and influences in the adoption of policies.

A fifth observation has been the futility and waste of war. We have been told that the little sum of 300 billion dollars was expended by this country to fight the recent war, a small matter of 75 billion a year or six and one-half billion a month or only 650 million in thirty days. Dear Doctor, for the small cost of thirty days of warfare a *million-dollar hospital building completely equipped could have been placed in every county of the United States*. Think of what could have been done with the proportionate expenditures that were made during the other forty-seven months of wartime waste. It might be a good idea and a good time for you to secure and read a little book, *The Anatomy of Peace* by Emery Reves, which is published by Harper & Brothers, 49 East 33rd Street, New York 16, N. Y., or get a little information on what Robert Lee Humber of Greenville, N. C., is trying to do towards the establishment of world peace. (I do not receive any commissions from Harper & Brothers).

My last observation is that the medical profession in the United States is composed of the finest group of men and women in this country. It's mighty good to be back with you and to be able to *sound off* without approval of higher authority.

H. B. JENKINS, M. D.

## GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*THE TREATMENT OF SYPHILIS WITH  
PENICILLIN

ALBERT HEYMAN, M. D.

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Although penicillin has been used in the treatment of syphilis for less than three years, considerable information has already accumulated regarding the value of this form of therapy. Since late sequelae may occur in syphilis long after the initial infection, many years of careful followup observation are necessary before final conclusions can be drawn as to the efficiency of new methods of treatment. Sufficient data are now available, however, to permit the use of penicillin in the treatment of certain types of syphilis.

An investigation of the value of penicillin in syphilis was begun several years ago by the Office of Scientific Research and Development in cooperation with Army, Navy, Public Health Service and civilian clinics. These agencies conducted an extensive research program to determine as quickly as possible for wartime purposes the most effective methods of treating the disease. The results of a major portion of this study have recently been published.<sup>1</sup>

It is the purpose of this report to present a practical summary of the available information regarding the treatment of syphilis with penicillin. Some of the subsequent statements are preliminary and may eventually be proved incorrect. This article, however, is written in an effort to clarify some of the misconceptions which now exist. Many of the treatment schedules now being used by practicing physicians are grossly inadequate and will result in harm to both patient and community.

There are several rules which must be observed in treating syphilis with penicillin.

1. The patient should be informed that the use of penicillin in syphilis is still a new method and that such treatment can be administered only with the understanding that the patient return at regular intervals for followup observation. This practice is necessary in order that relapses be detected as early as possible.

2. The physician must strictly avoid inadequate therapeutic measures such as oral penicillin, long and irregular intervals between penicillin injections, and omission of spinal fluid examinations. Although many of the recommended treatment schedules are admittedly inconvenient and expensive, the best results can be obtained only by strict adherence to methods which have been proved to be effective.

3. In the treatment of early cases of syphilis, every effort must be made to have the patient's marital partner as well as other sexual contacts, examined for this disease. Penicillin apparently produces a biologic cure in early cases of syphilis and the patient has no immunity against reinfection. He can therefore acquire the disease again soon after treatment, from either the original source or from his marital partner, to whom he may have given syphilis before his treatment was started.

It must be pointed out that the results obtained with the use of penicillin in recent months are not as good as those obtained earlier.<sup>2</sup> To a large extent, this is due to the changing mixture of the various fractions of penicillin known as F, X, K, and G. Fraction K has been shown to be ineffective in the treatment of experimental syphilis and this particular fraction has probably been present in increasing amounts in the commercial preparations of many manufacturers. Although the dosage schedules summarized below were effective a year or more ago, the changing character and potency of penicillin require that considerably larger doses be employed at present in the treatment of syphilis. Steps are being taken by the various manufacturers of penicillin to correct this situation, but until then larger doses of penicillin should be employed.

*Early Syphilis*

The early stages of syphilis respond most readily to penicillin therapy. The lesions in primary and secondary syphilis clear rapidly and the darkfield soon becomes negative after penicillin is begun. The serologic test for syphilis may not become negative for as long as six months or more, but a fall in titer is usually noted several weeks following the completion of treatment.

A total dose of 2.4 million units of sodium penicillin given in 40,000 units every three hours, day and night for seven and one-half days, has been demonstrated to be effective in approximately 85 per cent of the cases. Patients treated for early syphilis should be followed with quantitative serologic tests every six to eight weeks for at least one year. The response to treatment is considered satisfactory if the patient shows a steady fall in titer. A rise in titer of several dilutions or more indicates a relapse and the patient should be re-treated. We believe that a persistently positive serologic test of high titer at the end of one year should be considered an unsatisfactory result and these patients should also be re-treated. Examination of the spinal fluid should be made six months after treatment and again before the patient is dismissed.

Although a total dose of 2.4 million units of penicillin was found to be effective in early



syphilis, the increased amount of fraction K in recent lots of penicillin has led the Syphilis Study Section of the National Institute of Health to recommend doses of 5.4 million units of penicillin for the treatment of this condition during the next few months. This may be given in doses of 60,000 units every three hours for ninety injections for a period of eleven days.<sup>2</sup>

The addition of mapharsen and bismuth to penicillin treatment has been demonstrated to produce a marked synergistic effect. It has been suggested that doses of 40 mg. of mapharsen be given two or three times weekly for nine injections, and that five weekly injections of 0.1 Gm. of bismuth also be added to increase the efficacy of penicillin therapy. Arsenical and bismuth preparations may be given either during the course of penicillin or after it is completed.

Penicillin in beeswax-peanut oil mixtures is now being used in the treatment of early syphilis, but the results cannot yet be evaluated. We believe, however, that ten to sixteen daily injections of 600,000 units of penicillin in oil-beeswax will be effective in the majority of patients with early syphilis.

#### *Prenatal Syphilis*

Penicillin has been shown to be more effective in the prevention of congenital syphilis than arsenical and bismuth preparations.<sup>3</sup> Not only is penicillin therapy in pregnancy less toxic than older forms of chemotherapy, but it is also of considerable value when given during the third trimester of pregnancy. This is a definite advantage, since many patients with syphilis are seen late in pregnancy at a time when arsenical and bismuth therapy is least useful. The greatest advantage of penicillin therapy in prenatal syphilis, however, is the fact that the one course of penicillin not only protects the fetus, but is also the complete treatment for the mother. This is a most desirable feature, since antisiphilitic treatment of the mother is frequently neglected after the birth of the child, and clinical or neurorelapse often follows.

The dosage of penicillin in prenatal syphilis is the same as that in early cases. These patients, however, should be followed very closely during pregnancy and after delivery, and quantitative serologic tests should be taken at least every month. Retreatment during pregnancy is indicated if there is any evidence of a rise in serologic titer following therapy, or if a definite decrease in titer fails to occur. Children born of mothers treated with penicillin should have a serologic test for syphilis every four weeks until they are at least six months of age.

The combination of arsenical and penicillin therapy is also very useful in pregnancy. These drugs may be given simultaneously or the arsenic may be given after the completion of penicillin therapy.

#### *Congenital Syphilis*

The results in infants with congenital syphilis treated with penicillin have been satisfactory,

although relatively much larger doses are necessary. Many of the infants with congenital syphilis, however, are premature and malnourished at the onset of treatment and these children may die of an overwhelming infection during or soon after penicillin therapy. The importance of adequate nutrition and supportive care in these cases cannot be overemphasized. Serologic and spinal fluid followup in these children is similar to that in adults with early acquired syphilis.

We have found a total dose of penicillin of 100,000 units per kilogram of body weight to be effective in the treatment of infants with congenital syphilis. This dosage is given in equally divided amounts every three hours for eighty injections in ten days. Herxheimer reactions are frequently noted in these patients and the temperature may rise to 103° F. or more. We have not interrupted treatment in these cases, however, and have not noted any other untoward reactions.

We have recently treated a series of patients with late congenital manifestations such as interstitial keratitis, Clutton's arthritis, or eighth nerve deafness. These conditions do not respond well to treatment and the results were in general unsatisfactory.

#### *Late Syphilis*

Patients with latent syphilis (more than five years' duration, with a negative spinal fluid and no manifestations of the disease other than a positive serologic test) are frequently seen in private practice. There is, however, little information available thus far regarding the effectiveness of penicillin in this stage of the disease. The serologic test in these patients does not become negative following penicillin therapy, although a slight reduction in titer may occur. The only effective method of evaluating penicillin in these cases is to determine the frequency of late sequelae, and this cannot be estimated at this time.

A total dose of 3.6 million units of penicillin given in 45,000 units every three hours for ten days has been suggested for the treatment of this condition. The prognosis of late latent syphilis is in general very good, and this dosage of penicillin will probably be effective. It must be remembered, however, that in late latent syphilis no studies have as yet been done to support this form of treatment.

There have likewise been no reports on the value of penicillin in cardiovascular syphilis. We believe, however, that there is little to be gained by using penicillin in this condition. In an occasional instance, moreover, penicillin was thought to produce an exacerbation of existing cardiovascular lesions.

Benign late manifestations of syphilis, such as gumma of the skin and bone, respond well to penicillin and rapid healing of these occur with a total dose of 3 to 4 million units. Sufficient

time has not yet elapsed, however, to determine if relapses develop in these patients.

### *Neurosyphilis*

Penicillin has been demonstrated to be of considerable value in the treatment of some forms of syphilis of the central nervous system. The response of the spinal fluid in most patients with neurosyphilis is very satisfactory, and the cell count, mastic and protein determination usually become normal six months after the completion of treatment. The spinal fluid Wassermann reaction, however, may remain positive for much longer periods, but this does not necessarily indicate treatment failure. We have found the spinal fluid cell count to be the most sensitive index of relapse following penicillin, and we consider patients with a significant pleocytosis six months after penicillin to be treatment failures. Such cases are usually given fever therapy regardless of apparent clinical improvement.

We have obtained good results with 4 million units of penicillin in the treatment of asymptomatic neurosyphilis and in patients with tabes and meningovascular lesions. Patients with paresis and optic atrophy are being treated with a total dose of 6 million units, but the response has not been entirely satisfactory. Followup observations on all patients with neurosyphilis should include an examination of the spinal fluid every three or four months with particular attention given to the cell count.

At the present time a total dosage of 10 million units of penicillin is recommended for the treatment of paresis and optic atrophy. In our experience, however, these cases seem to obtain a better clinical response with fever therapy and we do not generally advise penicillin for these conditions.

### *Summary*

Penicillin is recommended as a valuable agent in the treatment of certain forms of syphilis. It appears to be as effective as arsenical and bismuth therapy and has added advantages in that it is non-toxic and does not require a prolonged course of treatment. Penicillin is a new method of treatment of syphilis, however, and careful followup observations are necessary in every patient treated with this drug.

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*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

## ARMY PROGRAM PREVENTS IMPORTING OF DISEASE

There is little or no risk of introducing foreign disease into the United States through returning military personnel from abroad, according to an announcement by the Office of The Surgeon General, which pointed out that the most careful estimates anticipate only moderate danger in a few cases.

This conclusion was reached after a worldwide survey by the Inter-departmental Quarantine Commission, which was jointly established by the Secretaries of War and Navy and the Administrator of the Federal Security Administration to study this problem.

With the end of the war and return of the bulk of combat forces, it is now possible to review actual results on a preliminary basis. Though tentative, highly optimistic conclusions appear warranted, the announcement stated.

To date no acute outbreak or secondary spread of an important disease has been reported. While more slowly evident diseases may be identified later, it should be remembered that the traffic of war has gone on for four years, giving ample time for discovery of such diseases.

The 440,000 hospitalizations for malaria reported among Army personnel during the war fall short of pessimistic predictions for what has proved to be the commonest infectious disease of troops abroad.

Even with the consideration that a portion of infected persons are liable to recurrence after their return to the States, conditions in this country are generally unfavorable for the spread of malaria and the chances of community risk are very small.

The special danger of cholera, smallpox, plague, epidemic typhus, and yellow fever is a matter of historical record. Immunizations were employed against all these diseases by the Armed Forces along with water purification, environmental sanitation, and disinfection and insect control. This preventive medicine program was exercised even under combat conditions and its effectiveness was shown by Army records. The high general level of sanitation, insect control, and alert medical care available here forms the final link in the protection of this country from imported diseases.

The risk of importing disease from abroad has been less in some respects than in normal pre-war traffic and the credit for these results has been attributed to the modern preventive medicine program of the Army and Navy.

Cases of exotic disease did occur, the announcement stated, but extensive investigation of likely hazards and critical application of preventive and corrective measures were effective in reducing risks to small proportions.



## EARLY TREATMENT CAN PREVENT BLINDNESS CAUSED BY GLAUCOMA

Nearly every one blinded by glaucoma, one of the most dangerous of all eye diseases, could be seeing today if he had gone to a doctor early enough for treatment, according to Jerome S. Peterson, M. D., of Brooklyn, N. Y.

Writing in *Hygeia*, health magazine of the American Medical Association, Dr. Peterson, who is District Health Officer in Brooklyn, says that the reason so many people are caught unawares is because glaucoma is tricky and manages to sneak its way in without letting the victim know.

"Your eyes cannot work without the presence of a watery fluid that flows in and out of the eye, through tiny canals," Dr. Peterson states. "Normally, just the right amount of fluid passes into the eye and out of it. But if ever, for any reason, there should be too much fluid coming in, or the canals leading outward should somehow be blocked, there may be trouble ahead—the trouble we call glaucoma. The surplus fluid accumulates within the eyeball, pressing upon the coat of the eye, which turns hard under the pressure.

"If nothing is done about it, the pressure shuts off the blood vessels nourishing the eye. Without food, no organ can live, and the eye is no exception. If glaucoma is allowed to progress unchecked, the victim is certain to become blind."

The cause of this disease is unknown. Physicians treat glaucoma by use of drugs which lower pressure in the eye and contract the pupil. Wearing glasses does not relieve the condition. If medical methods fail, it is customary to use surgery to establish proper drainage and to keep the pressure in the eye permanently low.

Continuing, Dr. Peterson says in part:

"Glaucoma appears in one of several forms—called specifically acute glaucoma and chronic glaucoma. No matter what form it takes, its early signs are confusing and misleading. A man who's headed for an attack of acute glaucoma, for instance, usually first feels mild, warning pains in and around his eyes. Things may seem blurred every so often; his eyes may turn red and start tearing, and perhaps he'll have a headache. After a couple of hours, though, the pain and the headache disappear.

"A few weeks or perhaps months later, though, . . . his eyes and entire head will rack with pain. He'll feel dizzy and nauseated. His vision will grow hazy—everything will become dark and dull. He'll feel as if he were in a dense fog.

"The man with chronic glaucoma, on the other hand, isn't likely to have any pain or sharp attacks. He'll probably have mild symptoms that are with him all the time—a one sided head-

ache, a heavy feeling in his eyes. When he reads for a short time, his eyes will ache. If he spends an evening playing bridge or at the movies, the things he looks at will start to blur. In dim light he won't be able to see well at all, and when he walks into the movies, or any darkened room, it will take him longer than most people to adjust his eyes to the dark.

"Another group of glaucoma victims who are not likely to suspect the truth about their eyes are those who have glaucoma without experiencing any symptoms, not even vague and slight ones. They may wonder what's wrong. That's largely because of the way in which glaucoma works. When glaucoma begins to destroy sight, it starts at the outermost extremes of the field of vision and gradually works toward the center. This means that while a man with glaucoma may have no trouble seeing straight ahead, his 'side vision' may have been completely destroyed."

## BENZEDRINE PREVENTS CONDITION DUE TO SLEEPING PILL POISONING

*Doctors Say If Patient Does Not Receive  
Immediate Treatment Complications  
Will Occur Leading To Death*

Benzedrine, a drug used in the treatment of certain depressive conditions such as that produced by alcoholism, has been newly applied in the treatment of sleeping pill poisoning and proved to be highly successful, according to two doctors writing in the June 22 issue of *The Journal of the American Medical Association*.

The doctors—A. W. Freireich and J. W. Landsberg of Hempstead, N. Y.—treated 14 patients with poisoning from sleeping pills by giving them injections of benzedrine into the veins. Thirteen patients recovered completely except for a slight headache. The one patient who died had not received, in the authors' estimation a sufficient quantity of the drug because it was not available.

The patients treated by Drs. Freireich and Landsberg were all admitted to Meadowbrook Hospital (Nassau County, N. Y.) in coma from an overdosage of sleeping pills taken with suicidal intent.

The symptoms in a typical case of poisoning with barbiturates are extreme depression of the central nervous system with coma, shallow breathing and low blood pressure falling rapidly to shock levels. The need for active and persistent treatment of sleeping pill poisoning cannot be stressed too strongly, the authors say. A false sense of security is felt on observing the state of coma. Unless a noticeable blueness of the skin with cycles of increased and decreased respiration or elevation of temperature has developed in addition to the other symptoms, the

usual impression is that the patient is merely in a deep sleep and will awaken after the effects of the drug have worn off. Valuable time may be lost if active treatment is not undertaken rapidly for death will occur from respiratory depression, bronchopneumonia or partial collapse of the lungs.

Picrotoxin has been a widely used drug in the treatment of this type of poisoning because it is a powerful stimulant of the nervous system. However, the authors felt that it was too dangerous because it commonly led to convulsions while the patient was still in a deep coma. As an example the authors cite the fact that in a series of 24 cases of sleeping pill poisoning in which the patients were treated with picrotoxin, five deaths occurred.

In conclusion the authors state: "The evaluation of any drug in barbiturate intoxication (sleeping pill poisoning) is very difficult, the individual response to different doses is so variable. No doubt some of the patients, if undisturbed, might have had a long sleep and awaken none the worse for their experience. However the need for active treatment to prevent pulmonary stasis (stoppage of the flow of blood to the lungs), congestion, pneumonia and atelectasis (partial collapse of the lungs) is always present. The shallow respiration of the person in deep sleep makes him a potential candidate for these pulmonary complications, and shortening the period of sleep, even though it may not be treatment essential to preserve life, is desirable."

#### GOUT OFTEN ASSUMES FALSE IDENTITY BY EXHIBITING MISLEADING SYMPTOMS

Gout, which is characterized by painful attacks in the joints, too often assumes a false identity by exhibiting symptoms common to other diseases such as bursitis or rheumatoid arthritis, according to three Boston physicians writing in the June 1 issue of *The Journal of the American Medical Association*.

Joseph P. McCracken, Philip S. Owen and Joseph H. Pratt made a detailed analysis of 100 cases of gout previously unreported. While the majority of patients were from three Boston hospitals, some were the private patients of Dr. Pratt.

Ninety-three of the patients had acute gout. The remaining seven suffered from chronic gout. This term is given to those cases in which persistent deformity or rigidity of joints occurs. In 32 of the patients gout had existed five years or more before the diagnosis was made, in 20 patients 10 years or more, in 14 patients 15 years or more, in eight patients 20 years or more and in two patients 30 years or more.

Gout symptoms begin with painful attacks in-

volving the joints, most often the foot or toe. The affected joint becomes red, hot tender and swollen. Fever follows with an increase in the white cells of the blood. These signs seem to indicate infection which the gouty patient actually does not have. The attack, lasting days or weeks, eventually ends, leaving the patient completely well until the next attack which may be years later.

Overeating, overdrinking, or injury of a surgical operation may bring on an attack to a person susceptible to gout by heredity. Repeated attacks of gout result in uric acid deposits in the joints causing bone destruction and a deforming type of regenerative joint disease.

One group under investigation by the authors, 91 were men and nine were women. Arranged by decades, the patients' ages varied: from 19 to 30 years 14 patients, 31 to 40 years 21 patients, 41 to 50 years 30 patients, 51 to 60 years 28 patients and 61 to 73 years seven patients.

A dangerous and poisonous drug, colchicum, brought rapid relief to 37 of 44 treated patients with acute attacks of gout. This drug controls pain and cuts short attacks of gout. The authors noted that pain was abolished in from 12 to 24 hours after the first dose was given.

Doctors have been cautious in prescribing this drug for treatment because it irritates the intestines and may seriously damage the kidneys. However, colchicum and its derivatives are rapid and effective in giving relief to gout sufferers. The physicians state: "Our experience indicates that the widespread fear of employing this drug deprives patients of a valuable remedy."

#### ARMY NURSES TO BE INSTRUCTED IN PSYCHIATRIC NURSING

That the post-war Army nurse will be given every opportunity to be a specialist in every branch of her profession was indicated this month by the Surgeon General's announcement that a program of instruction in psychiatric nursing would be established at the Brooke Medical Center at Fort Sam Houston, Texas.

"The important part of the program," said Colonel Florence A. Blanchfield, director of the corps, "is that psychiatric nursing is to be made a part of the Army nurse's basic education. In time, it is hoped that every nurse who serves with the Army will have been given the opportunity to take the course, even though she does not remain in psychiatric hospitals. She will be a better nurse for having had the instruction."

For the first classes, however, preference will be given to nurses who are interested in psychiatric nursing as a specialty. These nurses are asked to volunteer immediately. The first class will open June 14, 1946. The course will run for eight months and twenty-five nurses will be entered in each class. Members of the Regular Army Nurse Corps or nurses in Category I and II are eligible.

Army nurses interested in volunteering should contact: Director, Education and Training Division, Surgeon General's Office, War Department, Washington, District of Columbia.



## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

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### CAREERS' COMMITTEE SEEKS 40,000 NEW STUDENTS

Enrollment of 40,000 new students for basic professional nursing programs in 1946-47 has been adopted as one of its aims by the Committee on Careers in Nursing (formerly the National Nurse Recruitment Committee) recently set up by the National Nursing Council.

The word "enroll" is to be used instead of "recruit" because the latter has so distinct a wartime connotation. The nation-wide goal is above the 38,113 admitted in 1940, but more than 25,000 below the wartime peak of 65,521 admissions during the school year 1913-44.

Other objects of the committee which includes representatives of many fields of nursing, education, and counseling under the chairmanship of Edith H. Smith, dean of the School of Nursing, Syracuse University are:

To enroll graduate nurses in advanced courses to meet the demands of a growing national health program.

To enroll students in approved courses in practical nursing.

To stimulate the interest of college students in nursing as a career.

To help the public understand that improvement in programs of education for nurses brings improvement in nursing service.

To encourage non-professional participation in enrollment activities in order to increase public awareness of the career opportunities nursing offers and to stimulate interest in providing scholarships.

Men nurses as well as women are included in all the foregoing.

While a long-range program is recognized as a major need, the committee realized that it is now dealing with a continuing emergency, arising from nurse shortages that are still acute in many areas.

State committees, local groups, and schools are expected to carry the major portion of enrollment activities, since national funds are much more limited than during the war.

### *Georgia Schools Seek 300 New Student Nurses for 1946*

The eighteen Georgia schools of nursing enlist the support of the doctors, medical auxiliary and general educators in giving to the public information relative to the opportunities in the Georgia schools for qualified young women to secure an education and a career.

The Georgia schools are as follows:

University of Georgia, Athens, Miss Phoebe M. Kandel professor of Nursing Education; Crawford W. Long Hospital, Atlanta, Miss Ruth Babin, director of Nurses; Georgia Baptist Hospital, Atlanta, Miss Dana Hudson, director of Nurses; Grady Hospital, Atlanta, Miss Carrie M. Logan, director of Nurses; Piedmont Hospital, Atlanta, Miss Genevieve Garren, director of Nurses; St. Joseph's Infirmary, Atlanta, Miss M. Patrice director of Nurses; University Hospital, Augusta, Miss Miriam Ray, director of Nurses; City Hospital, Columbus, Miss Tressa Keneipp, director of Nurses; Emory University, Emory University, Miss Julia M. Miller, Dean of School of Nursing; Macon Hospital, Macon, Miss Elizabeth Branch, director of Nurses; Middle Georgia Hospital, Macon, Miss Erna Mathews, director of Nurses; Milledgeville State Hospital, Milledgeville, Mrs. Mae M. Jones, director of Nurses; St. Joseph's Hospital, Savannah, Sister M. Joseph, director of Nurses; Warren A. Candler Hospital, Savannah, Miss Louise Lenhardt, director of Nurses. There are three schools for Negro nurses connected with Grady, University Hospital and Columbus City hospitals.

#### *Entrance Requirements*

**Age:** The school of nursing usually sets the minimum age for admission at 18 years, but in special instances of high scholastic standing and evidence of physical and emotional maturity students may be accepted at 17 years.

**Personal:** Good health, emotional balance, seriousness of purpose, and suitable personality traits and abilities.

**Educational:** Graduation from an accredited high school is the minimum educational

requirement, and one or two years on a regular college program are highly desirable. High school subject requirements are as follows:

English .....	3 units
Social studies (history, civic, economics, sociology) .....	2 units
Mathematics (one unit must be algebra) .....	2 units
Science (biological or physical) ..	1 unit
Four units from English, social studies, mathematics, science or foreign language .....	4 units
Three units may be selected from any subjects which are accepted by an accredited high school toward its diploma, which meet standards of accrediting agencies .....	3 units
Total minimum requirement .....	15 units

Special consideration is given to the applicant whose record shows rank in the upper third of the class. Information may be obtained from the school relative to offerings, admission requirements and the testing program, all of which are aids in determining aptitudes for nursing.

For further information write to the school of your choice for the catalog, or to the State Nursing Headquarters, 131 Forrest Avenue, N. E., Atlanta.

#### NEWS ITEMS

The Sixth District Medical Society met at the State Hospital, Milledgeville, June 19. The members of the Baldwin County Medical Society were hosts. Scientific program: "Some Interesting Problems in Urologic Surgery," Dr. R. W. McAllister, Macon; "Sterility Problems: Radiological and Laboratory Aspects," Dr. Mass Mass, Macon; "When an Electrocardiogram?" Dr. Tom Ross, Macon; "Refrigeration Anesthesia," Dr. Milford Hatcher, Macon; "The Pathogenic Spirochetes, Motion Pictures Through Dark Field Microscope," Dr. M. Fernan-Nunez, Milledgeville. Official remarks by representatives of the Medical Association of Georgia. Officers are: President, Dr. J. A. Fountain, Macon; vice-president, Dr. Charles Fulghum, Milledgeville, and secretary, Dr. A. M. Phillips, Macon.

Dr. Frank Blalock, Atlanta, has been named medical director of Battle Hill Tuberculosis Sanatorium, succeeding Dr. J. C. Burch, who resigned to accept the directorship of the tuberculosis control unit of the City Health Department, Atlanta.

Dr. Hervey M. Cleckley, Augusta, professor of psychiatry at the University of Georgia School of Medicine, was elected a fellow of the American Psychiatric Association, which recently held its annual meeting in Chicago. Other Augusta psychiatrists elected members of the association were Dr. Ralph Gancher and Dr. William Vicary, of the Linwood Veterans Hospital. Named associate members were Dr. Philip Feinberg and Dr. Charlets C. Miracola, also of the Linwood staff.

Dr. C. G. Cox, Milledgeville, clinical director of the Milledgeville State Hospital, has been awarded the certificate of psychiatry, which designates him as a diplomate in psychiatry of the American Psychiatric Association. Notice of the award was sent by the American Board of Psychiatry and Neurology.

The Georgia Baptist Hospital, Atlanta, regular monthly meeting of the staff was held in the dining room of the Nurses Home, July 19. This was an important meeting. By-laws and regulations were discussed.

Dr. Samuel J. DeFreese, Monroe, announces the opening of his office for the practice of medicine and surgery in the Troy Theater Building, Monroe.

Dr. Warren S. Dorough, Atlanta, announces the reopening of his office, 618 Doctors Building, 478 Peachtree Street, N. E., Atlanta. Practice limited to surgery.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, June 11. Film on "Varicose Veins."

Dr. J. T. Giles, native Georgian, has recently been released from the Medical Corps of the United States Navy, and has become a member of the staff of the Mosely Clinic and Hospital, Donalsonville.

Dr. F. N. Harrison, Augusta, announces his return from the United States Navy to resume the practice of obstetrics at 407 Seventh Street, Augusta.

Dr. George S. Kerr, Dalton, who has been in Baton Rouge, La., recovering from an illness, has returned to Dalton to resume his medical practice.

Dr. A. Hamblin Letton, Atlanta, announces his release from active duty in the Medical Corps, United States Naval Reserve, and resumption of private practice in association with Dr. T. C. Davison, 207 Doctors Building, 478 Peachtree Street, N. E., Atlanta. Surgery and gynecology.

Dr. J. C. Hattaway, Edison, announces the arrival in Edison of Dr. Charles Tallon Louisell, Duluth, Minn., who specialized in eye, ear, throat and nose diseases, a graduate of the University of Minnesota. He will assist Dr. Hattaway for several weeks at the Hattaway Clinic, Edison.

Dr. W. C. McCarver, Jr., a native of Vidette, announces the opening of his office for the practice of medicine at Glennville.

Dr. Charlotte S. Neuberger, refugee from Germany, is Macon's second woman doctor. Dr. Neuberger recently completed a year of study at the University of Georgia School of Medicine, Augusta, passed Georgia medical examinations to practice as a physician. She became an American citizen Jan. 9, 1945, and took the oath of allegiance in Macon. Dr. Neuberger maintains offices at the Middle Georgia Hospital, Macon. Practice limited to pediatrics.

The Richmond County Medical Society held its regular monthly meeting at the University Hospital, Augusta, May 16. Dr. Perry P. Volpitt, chairman, announced the following program, consisting of a Symposium on Orthopedics led by Dr. Peter B. Wright, Augusta, professor of orthopedic surgery at the University of Georgia School of Medicine. The guest speaker was Dr. J. Warren White, Greenville, S. C. His subject was "A Practical Conception of Arthritis." Members of the medical staffs of nearby Army posts and doctors from neighboring counties were cordially invited to attend the meeting.



Dr. T. O. Vinson, Griffin, who has been health officer for Spalding County for several years, will serve as health officer for Spalding, Pike, and Lamar counties, which have been combined to form a health district.

The Southern Pediatric Seminar Twenty-Sixth Session meets July 15-27, 1946, Saluda, N. C. The following Georgia physicians are members of the faculty: Dr. W. L. Funkhouser, Atlanta; Dr. A. J. Waring, Savannah; Dr. Philip A. Mulherin, Augusta; Dr. Hines Roberts, Atlanta, and Dr. Lee Bivings, Atlanta. Also, many other Southern pediatricians. For further information, address Dr. D. Lesesne Smith, registrar, Infants' and Children's Sanitarium, Saluda, N. C.

The Thomas County Medical Society held its regular meeting at the City Hall, Meigs, June 19. Drs. John A. Garrett and J. N. Isler were hosts. The meeting was called to order by the president, Dr. George Dillinger. Tribute was paid to the late Dr. C. H. Ferguson. A communication was read by Dr. Rudolph Bell, acting secretary, from the secretary, Dr. Mary J. Erickson, who is on an extensive vacation. Dr. Kirk Shephard was unanimously elected to serve as secretary to the society during Dr. Erickson's absence.

The scientific program consisted of a round table discussion on "Typhus Fever," led by Drs. Arthur Hill, E. L. Hill, and Madero Bader. Many valuable points were brought out in the discussion and ideas exchanged which proved to be of much benefit to the local physicians, as well as to the members of the United States Public Health Service who are conducting a survey on typhus fever in this section of the country.

The American Congress of Physical Medicine will hold its twenty-fourth annual scientific and clinical session September 4, 5, 6 and 7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5 and 6. These courses will be open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Ill.

## OBITUARY

Dr. Robert T. Coleman, aged 75, practicing physician, died at his Young Harris home, May 16, 1946. Dr. Coleman was a native of Hayesville, N. C., and graduated from Young Harris College and the Chattanooga School of Medicine, Chattanooga, Tenn., in 1902. He had practiced medicine at Young Harris and the surrounding communities for the past 40 years, and served as superintendent of schools of Towns County for 16 years. He was a member of the Methodist church and a Mason. He is survived by his wife, Mrs. Bonnie Coleman; three daughters, Mrs. H. J. Griffes, Rome; Mrs. M. C. Myers, Blairsville, and Miss Bonnie Coleman, Young Harris. Funeral services were held at Young Harris Chapel, with Rev. H. L. Micham and Rev. R. L. Whitehead officiating. Burial was in old Union Cemetery.

Dr. Charles Henry Ferguson, aged 78, Thomasville, died at his home June 2, 1946. Dr. Ferguson was born in Savannah, son of the late George H. and Mary C. Ferguson. After graduating from city schools he began the study of medicine and graduated from the University of Georgia School of Medicine, Augusta, in 1901, beginning his practice of the profession at Boston. He moved to Thomasville about 40 years ago and since that

time has been in active practice there, one of the most able, particularly in his last years, when his consultations were invaluable. He went into many homes and in each he left the impression of efficiency and of kindness. They felt a confidence in his judgment and complete faith in his willingness to give everything to everyone he served. He was a member of the Thomas County Medical Society, the Medical Association of Georgia, a fellow in the American Medical Association, and a member of the Presbyterian church. His first wife was the former Carrie E. Creech, who died early in 1936. He was later married to Dr. Mary J. Erickson, Thomasville, who survives. Also surviving are one son, Charles E. Ferguson; two granddaughters, Dorothy Ball Ferguson and Mrs. Allen Crawford; two great-grandsons, Allen Neil Crawford and Charles Ferguson Crawford; two sisters, Mrs. Clara F. Owen, and Miss Lily Ferguson, Miami; brothers, Frank H. Ferguson, Miami, and Isaac S. Ferguson, Augusta. Funeral services were held at the residence, 115 Love Street, with the Rev. Marshall Woodson and the Rev. T. F. Callaway officiating. Burial was in Laurel Hill Cemetery, Thomasville.

Dr. Otho Napoleon Harden, aged 80, well known physician and surgeon, died at his home in Cornelia May 30, 1946. Dr. Harden was born in Fulton County, Georgia, and attended the grammar schools of Fulton County and Atlanta, completing his high school education at Eustis, Fla. He graduated from Atlanta Medical College, now Emory University School of Medicine, in 1894. He began his professional career at Homer, and later practiced medicine in Atlanta. In 1924 Dr. Harden located in Cornelia, where he resided until his death. He was a deacon of the Cornelia Baptist Church, a Mason, Oddfellow, and Woodman. He was local surgeon for the Tallulah Falls Railroad. He was a member of the Habersham Medical Society, the Medical Association of Georgia, and a fellow in the American Medical Association. For 52 years he was engaged in the active practice of medicine. He is survived by his wife, Mrs. Nettie Truitt Harden; two sons, O. H. Harden, Jr., Atlanta; Ralph E. Harden, Cornelia; two daughters, Mrs. John J. Lowe and Mrs. Henry L. Brewer, both of Cornelia; six grandchildren and one great grandchild. Funeral services were held at the Cornelia Baptist Church, with Dr. A. T. Cline, Toccoa, and Rev. A. A. Phillips, Cornelia, officiating. The members of the Habersham County Medical Society served as an honorary escort. Burial was in the Level Grove Cemetery, Cornelia.

Dr. Thaddeus Isaiah Hawkins, aged 58, prominent and beloved Griffin physician, died June 3, 1946, of a heart attack while visiting in Nashville, Tenn. Dr. Hawkins was born in Stilesboro, and attended Bartow County school, and graduated from Gordon Military College. He received his medical degree from Vanderbilt University School of Medicine, Nashville, Tenn., in 1914, and moved to Griffin to enter the practice of medicine. He was a member of the Masonic Lodge, the Elks, the Exchange Club, and the First Presbyterian Church. Surviving are his wife; one son, Richard Hawkins; a daughter, Mrs. Billy Hawkins, widow of Capt. Billy Hawkins, who was killed in action over Europe; brother, C. Ben Hawkins, West Point; four sisters, Mrs. R. L. Jackson, Misses Bessie and Campie Hawkins, all of Stilesboro, and Mrs. Raymond Davis, West Point. Funeral services were held at the First Presbyterian Church, the Rev. L. W. Topping, pastor, and the Rev. L. W. Blackwelder, rector of the Episcopal Church, officiating. Members of the Spalding County Medical Society served as an honorary escort. Burial was in Oak Hill Cemetery, Griffin.

*Dr. Champheys Holt Holmes*, aged 52, retired Atlanta chest specialist and staff member of the Atlanta Tuberculosis Association, died at a private hospital in Jacksonville, Fla., June 12, 1946. Dr. Holmes was born in Macon, and graduated from the University of Georgia in 1915, receiving four years later his medical degree from Johns Hopkins University School of Medicine, Baltimore. He began practicing medicine in Atlanta in 1922 and became a specialist in chest disease in 1931. He was formerly president of the Atlanta Tuberculosis Association. In 1938 and 1939 he served as president of the American College of Chest Physicians. He also was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the American College of Physicians, the Southern Tuberculosis Association, and the Trudeau Society. Surviving are his wife, Mrs. Jacqueline Swift Holmes, Atlantic Beach, Fla.; a sister, Mrs. Fleta Johnson, Macon, and a brother, John Holmes, Apopka, Fla. Cremation was at Jacksonville.

*Dr. Carl Gordon McCay*, aged 60, one of Atlanta's leading physicians, died at his residence, 729 Clairmont Avenue, Decatur, June 13, 1946. Dr. McCay was born in Franklin County and received his education at Young Harris College. He graduated from the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, Atlanta, in 1910. He practiced medicine in Atlanta for many years, and served on the board of directors of Crawford W. Long Memorial Hospital, Grady Hospital, and Emory University Hospital. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, a fellow of the American Medical Association, a Mason and a Shriner. He was a steward of the First Methodist Church, Decatur, and was widely known for his extensive civic and church work in Atlanta missions and other charitable organizations. His survivors include his wife; two daughters, Mrs. Richard G. Neill and Mrs. C. S. Manny; a brother, George W. McCay; a sister, Mrs. George L. King; his step-sisters, Mrs. Abner Rogers, California, and Mrs. Dan Arnold, Athens; three grandchildren, Betty Gail and Allen McCay Manny, and Richard Garrison Neill. Funeral services were held from the residence, 729 Clairmont Avenue, Decatur, with Dr. George Acree, the Rev. J. M. Powell, and the Rev. Charles Dunaway officiating. Burial was in the Decatur Cemetery, Decatur.

*Dr. Frank Henry Neuffer*, aged 39, Atlanta physician, was killed when the automobile he was driving overturned near Athens, June 16, 1946. Dr. Neuffer was born in Abbeville, S. C., son of the late Dr. G. A. Neuffer and Mrs. Neuffer. He graduated from the Medical College of the State of South Carolina, Charleston, S. C., in 1933. After post-graduate work in the North, Dr. Neuffer served as house doctor at St. Joseph's Infirmary. He had been associated with Dr. Murdock Equen about five years before entering the Army. He was one of the first Atlanta physicians to enter the Army in World War II, and was recently discharged from the service after five years in the Philippines. Dr. Neuffer was driving alone when the accident occurred, and was enroute to Atlanta from Washington, where he had visited. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, a fellow of the American Medical Association, and a member of the Atlanta Athletic Club. Survivors include his mother, Mrs. G. A. Neuffer, Abbeville; four brothers and three sisters. The body was sent to Abbeville, S. C., for the funeral services and burial.

## LIFE INSURANCE MEDICAL RESEARCH FUND

A new step in support of research in the field of diseases of the heart and arteries has been taken by the Life Insurance Medical Research Fund with the award of nine fellowships, totaling \$23,000, for post-graduate research and student training. Award of the fellowships, the first to be made by the Fund, coincided with the approval of eleven new grants, totaling \$162,000, to ten institutions for research in this field. These grants and awards bring to \$621,000 the allocations for research made by the Fund since it started operation last fall.

"Two types of fellowships are granted by the Fund," said Dr. Francis R. Dieuaide, scientific director of the Fund, in commenting on the awards. "The senior fellowships are given to graduates who have a doctor's degree in medicine or the related medical sciences. Junior fellowships are awarded to undergraduate students in medical schools who desire to take an extra year for training in scientific research. It is hoped that this program may serve to increase the number of research workers, particularly in view of the accumulated deficiency of such workers which developed during the war.

"Fellowships are open to residents of the United States and Canada. Senior fellows usually receive \$2,500 to \$3,500 a year, while junior fellows are given \$1,500 to \$2,000 a year."

It is expected that additional fellowships will be awarded later this year, Dr. Dieuaide said. Of the nine fellowships just awarded, he added, four are for post-graduate research into cardiovascular diseases and five are to medical students for training and research.

Dr. Dieuaide, who has become associated with the staff of the College of Physicians and Surgeons of Columbia University as clinical professor of medicine, announced that on July 1 the office of the Life Insurance Medical Research Fund will be established at the New York Academy of Medicine, 103rd Street and Fifth Avenue, New York City. The Fund is supported by 149 legal reserve life insurance companies in the United States and Canada, the 139 United States contributing companies representing 93 per cent of the life insurance in force for all United States companies.

Eight of the new grants are for study of the physiology of circulation or circulatory dynamics. The institutions to whom the grants were made and the research workers involved, as announced by M. Albert Linton, chairman of the Fund, are as follows:

Children's Hospital of Philadelphia—Dr. T. N. Harris for study of rheumatic fever.

Columbia University, New York—Dr. Katharine K. Merritt for study of congenital heart disease.

University of Southern California, Los Angeles—Dr. Clinton H. Thienes for study of the reaction of drugs on circulation.

Columbia University, New York—Dr. Rene Wegria.

Emory University, Atlanta—Dr. Eugene A. Stead, Jr.

Long Island College of Medicine, Brooklyn, N. Y.—Dr. William Dock and Dr. Jean Oliver.

University of Pennsylvania, Philadelphia—Dr. Carl F. Schmidt.

University of Texas, Galveston—Dr. A. N. Taylor.

Tulane University, New Orleans—Dr. George E. Burch. Wake Forest College, Bowman Gray School of Medicine, Winston-Salem, N. C.—Dr. Harold D. Green.

Yale University, New Haven—Dr. C. N. H. Long and Dr. J. R. Brobeck.

The post-graduate fellowships to be available in 1946 were made to:

Dr. Louis Horlick, provided satisfactory arrangements are made for him to work in the field of cardiovascular physiology.

Dr. J. Haskell Milstone, Yale University School of Medicine.

Dr. Roy L. Robertson, Emory University School of Medicine.



Dr. Kenneth F. G. Savard, University of Montreal School of Medicine.

The student fellowships were awarded as follows:

Gus G. Casten, Southwestern Medical College.

George T. Shires, Southwestern Medical College.

Donn L. Smith, University of Colorado School of Medicine, provided course work is satisfactorily restricted.

Lloyd H. Smith, Harvard School of Medicine.

William G. Turman, Syracuse University College of Medicine.

## TWELVE STATES TO FIGHT TB WITH MOBILE X-RAY UNITS

Mobile chest x-ray laboratories which will spearhead the expanding drive against tuberculosis in 12 states by providing complete facilities for mass examinations in any location was a featured attraction at the National Tuberculosis Association convention in Buffalo, June 11.

Designed to implement the broadening effort of the U. S. Public Health Service to identify and treat tuberculosis while it is still in curable stages, the new units—designed and built by the Westinghouse X-ray Division—are postwar versions of equipment widely used during the war by both military services and industry, according to H. D. Moreland, manager of the division.

Experience has proven a reluctance on the part of many persons to visit hospitals or clinics for such precautionary examinations so the procedure has been reversed and the clinic is being brought to the people. With this vastly improved mobility, health authorities will be able to arrange convenient mass chest examinations in any likely location—in industrial plants, schools or institutions; at large public gatherings; or in isolated rural communities.

The new units are available in either a tractor-and-trailer combination or in regular bus-type truck bodies. First tractor-and-trailer unit, one of two which will go to the Iowa State Board of Health, will be delivered within a month, Mr. Moreland said. Similar equipment is on order by health authorities in West Virginia, Ohio, Kansas, Wyoming, New Jersey, Oklahoma 3, Massachusetts and Hawaii.

Straight truck installations will go to health authorities in: the State of Kansas, West Chester County, New York, and Butler County, Ohio County, and Mercer County, Pennsylvania.

Each installation includes three separate compartments—one containing x-ray equipment, one a dark room for immediate on-the-scene development of films, and a third which may be fitted either as an office or with dressing rooms. Bodies are completely insulated and heating and cooling units insure comfortable operation in any climate. Tractor-and-trailer units carry their own power plants and all units have a 50-gallon storage tank to supply water for dark room use.

The x-ray operating room, largest of the three, is equipped with our high-speed PFX chest unit which employs the photoelectric timer invented by Drs. Russell H. Morgan and Paul C. Hodges and manufactured by Westinghouse. This equipment is capable of making the economically practical small films used for mass "screenings" at a rate of more than 800 per eight-hour working day. In addition it can be converted to make full-size film exposures—where this extra detail is needed—by making only three adjustments requiring less than three seconds.

Tractor-and-trailer units employ a two-ton tractor, have an overall length of approximately 41 feet, a maximum height of 11 feet 6 inches and weigh about ten tons. Straight truck units are of the cab-over-engine type, 28 feet in length. Special features available include electric road-sanding equipment for greater safety in sections where snow and ice constitute serious hazards.

## PENICILLIN AND SULFA DRUGS BRING RELIEF TO SINUS SUFFERERS

Sulfanilamide and penicillin drugs are proving highly successful in the treatment of sinusitis, an infection localized in the sinuses, or air pockets of the bones of the face and skull, according to William W. Bolton, M.D., of the Bureau of Health Education of the American Medical Association.

Writing in the current issue of *Hygeia*, Dr. Bolton says: "Perhaps the most frequent cause of sinusitis is the common cold, that sets up conditions tending to obstruct easy drainage of the sinuses. Once implanted, germs may continue to grow, depending on their own virulence and the resistance of the host."

Among the less common causes of sinus infection the author lists "working in smoky, dusty atmospheres, experiencing frequent extremes of temperature, and swimming. Immersion of the head has the inevitable result of filling the sinuses with water. In most people, it runs out freely and no harm is done, but in some the involuntary 'irrigation' results in infection."

"With the sulfa drugs and penicillin, physicians are finding the battle with sinusitis less of a problem," Dr. Bolton writes. "The drugs are now being used in a two-way attack. First, they may be given internally, that is by mouth or injection beneath the skin. In this way they are carried to all parts of the body, including the sinuses, in the blood stream. Thus, a 24 hour a day bombardment of the infecting germs is possible. In addition, these germ killers can be applied locally in the form of solutions, powders or sprays. Infected sinuses can be irrigated at regular intervals. A special form of penicillin spray known as aerosol penicillin, which is an extremely finely divided mist, has proved of special value in many cases. The microscopic droplets have the ability to penetrate remote, almost inaccessible areas high up in the nose, and points of infection which could not be reached, except perhaps through employment of extensive surgery, are put under control."

Additional avenues to attack sinusitis have been uncovered with newly acquired knowledge about the way the infection develops and progresses, according to the author. "It has been found that in a fairly large proportion of sufferers there is a definite evidence of some form of allergy. In such persons, as any hay fever sufferer knows, a prominent symptom is blocking of the nose and an outpouring of large amounts of watery secretion. The blocking is the result of marked swelling of the mucous structures within the nose. When this occurs, the openings from the sinuses are blocked too. As a result the secretion collects within these hollow cavities, and the stage is set for growth of germs, acute infection and then a chronic condition. If the allergy problem is not solved, swellings occur periodically, and just as periodically there will be a flare-up in the sinus disturbances. Sometimes these patients have developed a special sensitivity to the germs present in their own sinuses and air passages. Sometimes the allergy is related to certain foods, to dusts not ordinarily considered causes of sensitivity, to medicine which may be taken regularly, even to cosmetics. In any case, specific treatment in the form of a vaccine or some other means of desensitization can be given."

## "COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

Through the cooperation of Mead Johnson & Company, \$34,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art works best illustrating the above title.

This contest is open to members of the American Physicians Art Association and will be judged in June, 1947, at the Atlantic City session of the American Medical Association. For full details, write Dr. F. H. Redewill, secretary, Flood Building, San Francisco, Cal., or Mead Johnson & Company, Evansville 21, Ind.

## DRUG AIDS PATIENTS SUFFERING FROM BLOOD CLOTTING IN VEINS

*Swedish Doctor's Five Year Study Shows  
Patients Can Be Spared Pain, Ulcers  
And Even Death By Treatment*

A Swedish physician's five year study reveals that patients suffering from acute venous thrombosis—blood clotting in the veins—can be spared pain, ulcers, and even death, by treatment with heparin one of the drugs which prevents blood clotting.

Gunnar Bauer, M. D., surgeon in chief of the General Hospital in Mariestad, Sweden, presents his report in the May 18 issue of *The Journal of the American Medical Association*.

Between October 1, 1940 and Sept. 30, 1945, 209 cases of acute thrombosis of the deep veins of the leg were treated at the Mariestad Hospital. As a result of heparin treatment pain, fever and swelling were eliminated; the average period in bed was shortened from 40 days to about 4.7 days; the death rate was reduced to less than one tenth of what it was before.

The author reviewed a series of 264 patients with thrombosis treated by accepted methods over a 10 year period and found that 47 died. In the heparin treated group, covering a five year period, only three died.

Dr. Bauer made an intensive study to prove his theory that the starting point of the clotting process was in the lower part of the leg. X-ray diagnosis used on 190 patients, showed in over 98 per cent various phases of evolution of the clot in this region.

The author suggests that this knowledge should be an important aid in diagnosing the disease in its early stage. Whenever there is a rise in temperature without any obvious reason, or a pain or a stitch in one side of the chest, the lower part of the patient's leg should be immediately examined. X-rays are the only way to confirm the diagnosis. However, if swelling and blueness of the skin are present it indicates that the disease is in an advanced stage and unfortunately it is then often too late for treatment.

One of the unpleasant after-effects of this disease has always been ulcers of the leg. Dr. Bauer states that from 80 to 90 per cent of leg ulcers which are thought to be due to varicose veins are really caused by an earlier deep thrombosis. Heparin treatment clears up the infection in a few days and eliminates such painful and incapacitating developments in the future.

The author summarizes his suggested method of treatment in four steps: "(1) early diagnosis, (2) immediate intensive heparinization (by injection into the veins), (3) movements of the

leg from the beginning, and (4) getting the patient out of bed the moment the acute thrombosis symptoms disappear, before the termination of heparin injections."

## EMOTIONAL INSECURITY IN CHILDHOOD MAY AFFECT ADULT LIFE

A child who feels unwanted by one or both parents will have difficulty all his life feeling at home in any household, Henry C. Schumacher, M.D., writes in the July issue of *Hygeia, The Health Magazine* of the American Medical Association.

Dr. Schumacher, who is director of the Cleveland Guidance Center and consulting physician at St. Ann's Hospital in Cleveland, believes that the way a child thinks and feels about his parents will influence his attitudes in later years.

"His ideas of marriage, the duties of parents toward their children, how to bring up children, his relationships with his fellow men at work and at play—all these relationships will be colored by his own childhood feelings, Dr. Schumacher says. Continuing, he wrote:

"Of course, emotional insecurity in a child may come from other things than only from feeling that he is unwanted. There are parents who go too far the other way and are overprotective and oversolicitous. Some even go so far as to dodge disciplinary measures because they're afraid of antagonizing their own children! They anticipate every want, so that the child has no chance to show initiative. Naturally, the child never learns to cooperate and knows nothing about group rights. So he becomes self-centered. He expects to receive everything, and he doesn't think of giving anything. What a poor preparation for life this is! That child, when he grows up, will avoid responsibility, will have little or no self-control, and, because of his selfishness, will have the utmost difficulty in making a reasonable adjustment to others. He will be unable to make sound friendships, or to keep them, because friendship calls for mutual consideration. And this is exactly what he has failed to learn, because of his parents' oversolicitude. . . .

"A child who depends too much on parental guidance has had inadequate preparation for adult life. There must be a gradual drift from parental discipline to self discipline. There must be a development from the impulsiveness of the baby to the self control of the emotionally mature adult."

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**POSITION WANTED: Young physician, eligible for discharge from military service July 1st, desires position with older physician doing general practice and surgery in small town. Write 95 Engineer Drive, Benning Hills, Columbus, Ga.**

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## THE TUMULT IN MEDICINE—A PSYCHOSOMATIC ANALYSIS

RALPH HILL CHANEY, M. D.  
*Augusta*

My forefathers came to this country in the 1620's in order to escape from the servile bondage that resulted in a totalitarian state: to seek a new home in a land where freedom existed—freedom of speech; freedom of worship; freedom from fear; and freedom from want. During the early days of our nation's upbuilding those freedoms remained a cherished heritage—our forefathers fighting and winning the Revolutionary War to maintain freedom from taxation without representation. It is my purpose to endeavor to show that even though I, together with all honest thinking men, realize that much good exists in some of the present-day social trends, that furthered by the unbridled ambitions and unrestrained ideas of those individuals now dominating their promulgation can destroy rather than give us freedom.

I am not unaware of social change in the course of our country's development. When my forefathers came to this land each family and each community was a self-sustaining unit and each existed by the sweat of its own brow, but as colonies spread and boundaries widened, a necessity for specialization developed and each individual became adept in the formation of some special product and dependent upon his neighbor for those other necessities of life which he himself did not make. As a natural conse-

quence there developed groups of manufacturers, retailers, employers and employees. With the extension of our boundaries toward the West and the opening of vast resources, with the consequent demand for supportive material, there rose a demand for cheap labor and the enormous immigration of European peoples to our shores began. Primarily these peoples came from Northern Europe and begot those hardy descendants who developed the farms of our western frontier, but later the peoples from Central and Southern European areas began to inflow. Because their natural habitat was in crowded cities of their homelands, they naturally gravitated into our larger cities, which, even then as now, did not have the possibilities of expanding housing fast enough to accommodate them, thus overcrowding and slums arose, together with their coincident social and health problems.

Prosperity and depressions play a great part in the social well-being of peoples. I would not have you think that I am ignorant of those things which take place as these cycles in our economic existence pass. My life span reaches back sufficiently far to remember the bread lines of 1893, the soup kitchens of 1897, the hunger of 1914, the depression of 1921 and the relief lines of the early 1930's. In the process of gaining an education I sat and worshiped at the feet of Jane Adams at Hull House in Chicago, spent many long hours at Hiram House in Cleveland and lived at the University Settlement in Philadelphia during my years as an undergraduate in medicine at the University of Pennsylvania. Later I spent years at Blockley in Philadelphia, Bellevue in

New York, Kings County in Brooklyn, and for eleven years directed the ward services of the University Hospital in Augusta. Thus I believe I have had the opportunity to observe and intimately see how the other side lives. In all this experience the fundamental factor, which has impressed me, is the potential ignorance of people. For some reason we seem to have lost that insinct for self-preservation, which even the gopher and the squirrel possess; namely, to save up in time of plenty for the day of adversity. I could relate incident after incident where family groups with more than average income spend so lavishly in the periods of plenty that they must be repeatedly succored by relief organizations in the lean periods. This is a matter of education and is a necessary factor in our social progress. We can repeatedly stuff the peoples of poverty row but we will never advance until we educate them to a self-sustaining level.

Likewise I would not have you think I do not realize the good which the labor unions have done in improving human existence. During my college vacations I worked in steel mills when twelve hours a day seven days a week was the standard of existence, and when the man, who in the fatiguing struggle dropped out of line, was thrown into the gutter to shift for himself, another taking his place. I realize how much shorter hours, better working conditions and better wages have done to improve the living habits of many, but I also realize that when large labor groups come so completely under domination of a single man the whole economic structure of our country can be made to totter with his breathing. It is then things reach a totalitarian *impasse* that threatens to remove from all of us those freedoms our forefathers fought for and which your brothers, my brothers, your sons, my sons and myself all have fought two world wars to save.

Why all this unrest in regard to medical

care? Two reasons: the first being improper distribution of medical facilities, in which I include doctors; and second, distorted statements and analyses of physical fitness. In regard to the first, no honest, clear-thinking individual, be he layman or physician, will deny that many areas of this country, and especially in Georgia, are without adequate hospital and physician coverage. Just why has this come about? Largely because as the older country doctors have passed to their rewards their places have not been filled by the rising generation. This again exists because of two reasons: one that the younger generation of medical men are not trained to work efficiently in the absence of hospital and laboratory facilities and so seek locations where they exist. The other is that with the widespread development of hard surface roads and wide distribution of automobiles, the rural resident by-passes the country doctor and goes to the doctor in the nearest large city, except for trivial sickness. The second major problem, distorted analysis of physical fitness, comes largely from the repeated statement that in the past war five million men were rejected by the draft boards as unfit for military duty. Simple mathematical correction of this figure shows a 13.5 per cent error and the true figure to be 4,217,000. Of the total rejections, 444,800 were the manifestly disqualified; namely, the totally blind, deaf, dumb, legless and armless; 701,700 had mental disease; and 582,100 were mental defectives. So far as I know there is no medical care program which could have made this group serviceable from a military standpoint. Excluding these, 2,488,400 remain for consideration. Of these, 320,000 were rejected for muscular defects, 280,000 for syphilis, 220,000 for hernia and 160,000 because of "eyes." Rehabilitation may aid some of the muscular defect group in becoming more useful citizens, but it could never make



them fit for military duty. Rehabilitation programs are already a part of federal and state-aided programs. The 280,000 syphilis rejections came in spite of all our existing laws, both federal and local, and could not have been changed by the number in that group. Nor could the nearsighted, the farsighted or the astigmatic individuals have had their long, short or abnormally curved eyeballs changed by any medical care program. However, if you want to go into the field of scientific breeding of human beings in the same way as we breed horses and pigs it is very probable that in a number of generations these variations from the normal could be eliminated. This, as yet, is not advocated by even the most advanced social thinking in this country. Thus we see that the appalling five millions so glibly spoken of dwindles down to 1,508,400. If this number, hardly more than 1 per cent of our population, is the basis for so much hue and cry, it certainly can be corrected without altering our social order.

Before considering the Wagner-Murray-Dingell bill, which represents the most recent socialistic move in this country, it may be well to consider some of the trends behind such movements and legislation. Recently when Mr. Arthur J. Altmeyer, chairman of the Social Security Board, appeared before the Senate Committee on Education and Labor he was asked who was the promulgator of the bill. He stated that he did not know exactly but thought it was probably the brain child of the individuals introducing it. This was apparently an evasion of the question, for certainly as well informed individual as Mr. Altmeyer knows the history of the International Labor Organization which had its main office in Geneva until the onset of World War II when it was moved to Montreal. The ILO was sired by the International Association for Labor Legislation and its affiliates, one

of which was the American Association of Labor Legislation, from which Samuel Gompers of the American Federation of Labor withdrew because its objectives were un-American. The ILO was only a private agency until 1919 when, under Part XIII of the Versailles Treaty, it became a subsidiary of the League of Nations. Even prior to the rejection of the treaty as a whole, the Senate of the United States rejected Part XIII. Hence from 1919 until 1934 the United States participated in the ILO only through unofficial observers. However, the undercurrent continued to work until finally in an unheralded joint resolution passed by Congress, the United States became a "member state" of the International Labor Organization and accepted the ILO constitution.

Just what did this mean? The stated purpose of the ILO is "to promote social justice in all of the countries of the world. To this end it collects facts about labor and social conditions, formulates minimum international standards, and supervises their national application." According to the constitution of the ILO, and I quote, "By accepting the Constitution of the International Labor Organization the States (national governments) agree to the preparation of international rules for social insurance by a permanent body . . . of experts in social matters; namely, the International Labor Office, and to the elaboration of these rules by a permanent congress; namely, the International Labor Conference, consisting of representatives not only of governments but also of classes directly concerned, capital and labor."\*

The governing body of the ILO itself makes by a two-thirds majority vote recommendations, which then undergo consultations in which they are refined and presented to the conference. If the conference passes them by a two-thirds majority they

\*Provisional Bulletin No. 5 Inter-American Committee on Social Security (ILO) p. 29.

are accepted and become draft conventions and copies are sent to each ILO member state. Such member; namely, the United States, must then draft conventions before their legislative bodies within a year and each member state is bound by agreement to submit annual reports to the ILO showing the manner in which the proposals have been acted upon.

At the Philadelphia conference in April 1944 seven recommendations, including one on medical care, were adopted, these apparently being the outcome of some 114 proposals for the "improvement and unification of medical care services" considered during 1943 and 1944. President Roosevelt, speaking at this conference, said: "Under the constitution of the International Labor Organization these recommendations are forwarded to member governments for submission by them to their respective competent national authorities. I shall accordingly submit them to the Congress in the regular way when certified copies are received."

In some instances they are submitted as received and in other instances they are rewritten by their sponsors in a form deemed more acceptable and more probable of passing. Such is apparently the method sponsored in the instance of the Wagner-Murray-Dingell bill.

Just how is the ILO financed? By appropriations from the member states. I pay federal taxes and you, each and every one of you, pay them either directly or indirectly. I do not object to paying taxes for the support of the Army, the Navy, or the domestic necessities of our government, but I do object to paying taxes so that an appropriation can be made to an organization so that organization may have funds to support a lobby in Washington which attempts to force legislation that regiments us down our throats. I object to paying for the support of legislation with which I do not agree, and without my consent.

Considering the Wagner-Murray-Dingell bill itself, it was first introduced as S. 1161 in 1943, again modified as S. 1050 in early 1945 and finally in amended form as S. 1606 in October 1945. Primarily the bill contained taxation measures and therefore was referred to the Senate Finance Committee and to the House Ways and Means Committee. Each time because the amounts demanded were so excessive that no financial expert—because they demanded sums greater than the entire expenditure for the domestic economy of the government in 1942-43—could see means of raising, the measure died in committees. The proponents of the latest bill, hoping for more favorable action, left taxation measures out of the bill so that it was referred to the Committee on Education and Labor of the Senate where the chairman was one of its sponsors and therefore sympathetic toward it. Hearings are now in progress and unfortunately only those favorable to its passage are given the green light, and those unfavorable are goaded as though they were unfortunate mental degenerates.

The bill itself is in three titles, the third title being a rider which makes any part of the bill law even though some sections are rejected. The first title has the approval of the American Medical Association and the Medical Association of Georgia. This provided for grants to states for health services, and while administered through the Public Health Service are carried on at the state level. These provide for advancing control of tuberculosis and syphilis, for advancing the maternal and child welfare program, for advancing the crippled children's program, and for advancing medical care for needy persons.

The second title is labeled "Prepaid Personal Health Service Benefits" and contains a multitude of evils as well as those questionable goods which its sponsors claim for it. The main objections are that it does not give free choice of physician to the



patient, and regulates the mode of action of the physician. The bill definitely states that each individual shall choose his own physician, but from among the group of physicians who have indicated they will cooperate with the program. Then it states if the panel of the physicians they choose is filled they must take a second choice and so on. It also states that ordinarily a consultant or specialist will only be called by the patient's individual physician, but the patient may apply to his local medical administrative officer for this opportunity. Perhaps this is free choice, but it is difficult to see the freedom.

From the physician's point of view the bill provides that his status as a practitioner, a specialist or as a consultant rests in the hands of an Advisory Council which is dominated by lay members; that the method of payment may be according to the division of people to be served, may be according to a fee basis for service rendered, may be on a salary basis, or may be on a combination of these methods as the Surgeon General approves. In the final analysis, the status of the physician in so far as his income is concerned is in the hands of a single man or his representative. To me this represents regimentation with a vengeance.

Any plan of government medical care must be judged by the past. In our country the only comparable experiments have been in our Veterans' Service during the past twenty-five years. The recent shake up in that service does not offer much promise that this new and much more unwieldy experiment would not be equally fraught with dangers and result in an equal or worse deterioration of medical service. To judge from the experience in Great Britain where Panel Medicine has been in vogue for years we find a physician to make a living must see approximately 70 patients daily. I do not have to ask you what the quality of that

care amounts to, a "Good Day" and a "Good Bye." Likewise recent reports show heavy fines meted out to practitioners who, with the best of intent and with excellent results, overstepped their designated limitations and invaded the province of the specialist. Such instances are going to delay and often act adversely to the benefit of the patient.

In view of my personal conclusions that much of the evil that arises from modern social trends is due to a failure of dissemination of information, I have recommended to the House of Delegates of the Medical Association of Georgia at this meeting:

1. That the House of Delegates, through established committees or through a newly setup committee, undertake the education of its own members in regard to recent social trends and legislation.

2. That the House of Delegates instruct the Woman's Auxiliary to at once undertake an educational program to reach all women's organizations, civic bodies, church groups and other related organizations, to instruct them in regard to social trends, especially such trends as are represented by the Wagner-Murray-Dingell bill.

3. That the House of Delegates set up at once means of study and promulgation of a state-wide prepayment medical care plan.

#### JOURNAL QUESTIONS POWER OF VITAMIN E TO RELIEVE HEART DISEASE

An editorial appearing in the June 29 issue of *The Journal of the American Medical Association* challenges the reported miraculous powers of vitamin E in heart disease and states that "far too often of late there has been overemphasis in the popular press on research too fresh from the laboratory and too inadequate as to evidence to permit evaluation."

*The Journal* article says:

"Announcement in newspapers and particularly in TIME that large doses of vitamin E will bring relief from all common forms of heart disease once again prompts discussion of the manner in which the results of medical research should be brought to the attention of the public. Far too often of late there has been overemphasis in the popular press on research too fresh from the laboratory and too inadequate as to evidence to permit evaluation. The reported discovery of new and almost miraculous powers of vitamin E needs careful evaluation and confirmation because the substance had already been investigated by many competent clinicians and found wanting. Nothing in the known pharmacologic actions of vitamin E would lead one to suspect either a vasodilating (dilating of blood vessels) action, a myotonic (tonic spasm of a muscle) effect or an ability to repair damaged heart muscle in human beings."

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

# VISUALIZATION OF A TRAUMATIC POPLITEAL ANEURYSM BEFORE AND AFTER OPERATION *Report of Case*

THOMAS HARROLD, M. D.  
MAX MASS, M. D.  
*Macon*

The surgical treatment of an aneurysm is difficult and tedious at best, and is frequently complicated by the distortion and displacement of anatomic landmarks. If the aneurysm occurs in a region where an artery normally divides or gives off branches, as do the carotid, subclavian and popliteal for instance, the surgical approach should be simplified if the surgeon knows in advance the exact location of the aneurysm and its relation to any branching arteries in the field of operation. It is also of importance to know as much as possible about the collateral circulation in case ligation of a large artery is contemplated.

It occurred to us that much of the desired information could be obtained in a case of popliteal aneurysm by the use of 70 per cent diodrast as advocated by Robb and Steinberg in their epochal work of visualizing the heart and larger vessels. They state that "Diodrast is a suitable radio-opaque medium since it is freely miscible with blood, rapidly eliminated, relatively nontoxic, inert, and nonirritating except at the site of injection in a few patients . . . Mild thrombophlebitis developed at the site of injection 33 times in a series of 238 cases." Otherwise there were no serious ill effects.

Since 1923, when arteriography was first attempted *in vivo* followed by the outstanding contributions of Reynoldo dos Santos and Egas Moniz, remarkable advances have been made. A rather extensive literature is now established emphasizing the diagnostic value of contrast angiography.

Hitherto obscure symptoms due to dis-

eases of the cerebral vessels have been clarified by the work of Moniz, Gross and others. Steinberg and Robb have helped establish visible anatomic criteria for the diagnosis of organic heart disease by their remarkable work in visualizing the heart chambers and the pulmonary circulation.

The greatest difficulties encountered in this work had to do with the selection of a suitable contrast media. Hippuran, uroselectan, iopax, perabrodil, thorotrast and, finally, diodrast, were used. The latter most nearly fills the requirements of an ideal angiographic medium, but most investigators report many untoward effects. Steinberg and Robb regularly observe falls in the blood pressure as much as 30 mm. of mercury, tachycardia, sensation of intense heat, weakness, nausea and vomiting. Occasionally urticaria and angioneurotic edema develop, which may be relieved by epinephrine. Very rarely angiospasm has been noted but most frequently the injection relieves spasm. Sgalitzer has used uroselectan in the treatment of vasospastic conditions and reports excellent symptomatic relief, using 20 cc. of a 40 per cent solution.

The success of all angiographic procedures must depend on painstaking preparation. The use of a proper concentration of diodrast is important. Gross found that 70 per cent diodrast produced Jacksonian seizures in 3 out of 12 cases of cerebral angiography, but that 50 per cent solution produced no untoward effect. He has injected as much as 45 cc. of 70 per cent solution without serious consequences.

It is felt that the visualization of the aneurysm in the case here reported was of real value and deserves trial whenever the opportunity presents itself.

## REPORT OF CASE

D. A., a male Negro farm laborer age 42, was admitted to the Macon City Hospital, Feb. 19, 1942 complaining of pain and swelling in the calf of his left leg.

The family and past histories were unimportant.

The present illness dates from Sept. 15, 1941, at which time he received a pistol wound through the upper portion of the calf of the left leg. His leg was quite swollen and painful and he was unable to work for about one





Figure 1.

Films made Feb. 21, 1942 show 70 per cent diodrast visualization of traumatic popliteal aneurysm. Note absence of vessels distal to aneurysm.

month. Following this he was able to do ordinary farm work for about three months, but the swelling never disappeared completely and he noticed a small lump on the lateral surface of the leg at the wound of exit. About one month before admission there was marked rapid increase in both swelling and pain, which resulted in complete disability within a few days.

Physical examination on admission was essentially negative except for the local condition. Temperature 98.8 F.; pulse rate 105; respiration 22; blood pressure 140/85; urinalysis negative; hemoglobin 100 per cent; leukocyte count 11,400, with 86 per cent polymorphonuclears.

Examination of the left leg showed a rounded swelling in the upper portion of the calf about two inches below the popliteal space. This tumor was about four inches in diameter, tender, with definitely expansile pulsation and apparently lying beneath the gastrocnemius muscle. A bruit could be heard and felt over the mass but was not of the "to and fro" type. Blood pressure in the leg below the mass was 115/70. The pulsation was stopped by compression of the femoral artery but the pulse rate dropped only from 104 to 97, and this was not considered significant. There was moderate edema of the lower leg and ankle. There was evidence of injury to the musculocutaneous nerve with anesthesia of the dorsum of the foot, and weakness of the peroneus longus and brevis.

*X-ray procedure:* We arranged a biplane radiographic system by employing our portable apparatus and prepared by preliminary practice to make four exposures during the time of injection. An assistant compressed the femoral artery by firm pressure with the thenar eminence of his hand over Scarpa's triangle; 20 cc. of 70 per cent diodrast were injected as rapidly as possible

into the femoral artery while two anterior and two lateral exposures of the knee area were made, Figure 1.

*Operation,* Feb. 24, 1942. Anesthetic: nitrous oxide, oxygen and ether.

*Procedure:* Through a generous mid-line incision over the aneurysm the sac was exposed. The tibial nerve was identified and retracted medially, and some fibers of the gastrocnemius and soleus were split or divided to provide adequate exposure. Considerable scar tissue, due to the bullet wound, added some difficulties to the dissection which was quite tedious. When the sac was opened, the x-ray findings were verified as the popliteal artery opened directly into the upper portion of the sac and the mouths of three vessels leaving it could be identified. These were the posterior tibial and peroneal, which were close together, and the anterior tibial which was in a different lobule of the aneurysm in its most inaccessible portion. It was evident that no reconstructive operation was possible, so the popliteal, posterior tibial and peroneal arteries were ligated. Due to its position it was found impossible to ligate the anterior tibial artery without extending the dissection to an unjustifiable degree, so a pack was placed in this area and the muscles were sewed snugly over it. Very little bleeding occurred and the pack was removed ten days later.

*Postoperative course:* No complications occurred and the wound healed *per primum*. At no time was there any evidence of inadequate circulation in the foot or lower leg. Definite pulsation was palpable in the dorsalis pedis and posterior tibial arteries seven days after the operation. Most of the edema had cleared up before his discharge from the hospital twelve days postoperatively. Partial foot drop was still present.

*X-ray Procedure:* Diodrast was again injected as before on March 5.

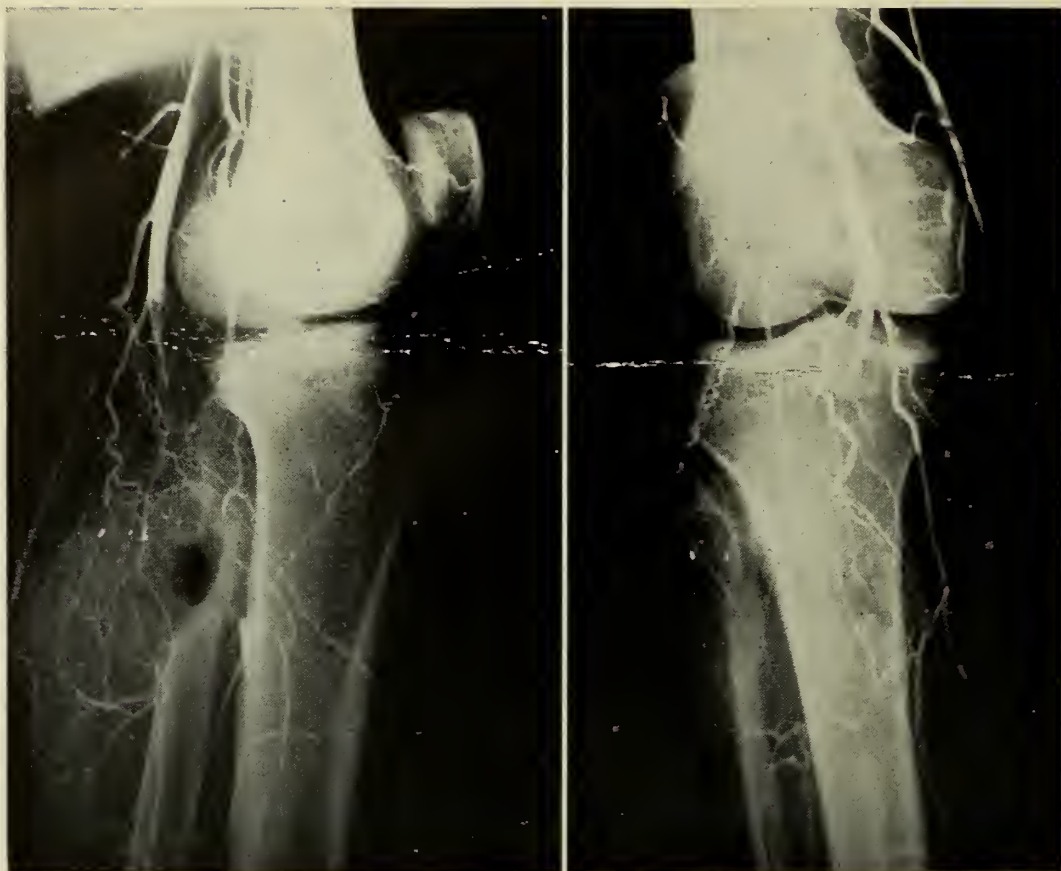


Figure 2

Films made March 5, 1942. Postoperative arteriogram demonstrating obliterated aneurysmal sac and abundant anastomoses.

*Comment:* It is to be noted that severe pain, probably representing spasm of the blood vessels, developed during this second injection of diodrast, which lasted for several hours and there was residual soreness for several days. This second injection was made only nine days after the operation. It seems likely that the circulation had not re-established itself sufficiently in this length of time to prevent stagnation in some areas, with resulting chemical arteritis and possibly phlebitis. After he was discharged from the hospital this man developed gangrene in his little toe and it had to be removed. We feel that this second injection of diodrast probably contributed to the development of the gangrenous toe and that our use of this technic, so soon after the ligation of a major artery, was ill advised. It would probably be perfectly safe after a longer interval.

*Follow-up note:* When last heard from, seven months after operation, his family physician reported that he was doing his customary farm work, and on that day he was seen picking cotton in the field.

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#### QUESTION USEFULNESS OF QUARANTINE AGAINST POLIOMYELITIS

Usefulness of quarantines established by some states to prevent the spread of poliomyelitis is held "highly questionable" by *The Journal of the American Medical Association*. In the July 27 issue, *The Journal* says in an editorial:

"This year, as in previous years, some sections of the country have developed an exceptionally high incidence of poliomyelitis. A few cities in southern Florida were involved in this manner. One of the neighboring states considered the establishment of a quarantine against Florida residents. Georgia actually imposed such a quarantine against all persons coming from the former state, even including Pensacola, which is 402 miles from the nearest city in which there has been an outbreak of poliomyelitis that could possibly be considered as epidemic in nature. The usefulness of this interstate quarantine is highly questionable. The overwhelming consensus of authorities in epidemiology and public health is that such interstate quarantine does not serve any useful purpose in preventing the spread of poliomyelitis. In the absence of more specific knowledge on the methods of spread of the poliomyelitis virus than is now available, state quarantine can only be considered reminiscent of the old practice of shot-gun quarantine against yellow fever before learning the role of the yellow fever bearing mosquito."



## THE ETIOLOGY OF CONVULSIONS

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Atlanta

In selecting this topic we were cognizant of the fact that this subject had previously been presented before this society. However, because of many prevailing misconceptions regarding the etiology of convulsions, we felt justified in briefly discussing this problem again.

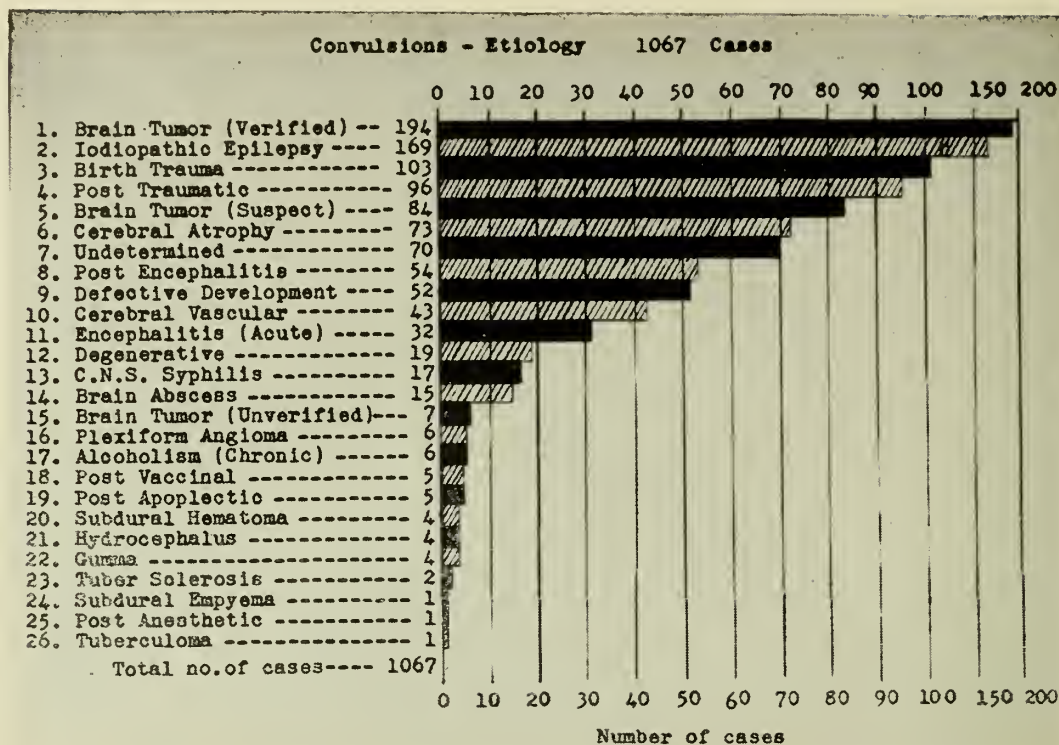
The discussion to follow is based upon a survey of over one thousand cases seen in practice by my associate or by myself. It must be recalled that these cases were seen in a practice limited to neurologic surgery and perhaps our figures for organic pathology are at variance with a similar series of cases compiled by an internist or neurologist. For the most part, the presenting symptoms of this group was convulsions. In order to clarify the term convulsions as used in this discussion, it should be pointed out that the term as used refers to all types of seizures, whether these be generalized, focal, psychomotor or *petit mal*. The term epilepsy, it is to be noted, is reserved for a definite group of convulsive attacks.

Slide 1 represents the classification as to the etiology of the cases studied for this discussion. It is to be noted that no attempt has been made to separate these cases into age groups. Originally we had planned to discuss this problem as it presents itself in childhood and in adulthood but time would not permit. In reviewing this slide, it becomes readily apparent that in the over-all series the largest group is represented by the brain tumors. In this series, which seems to be large enough to secure a general impression of the problem, the brain tumors as verified either at operation or autopsy constituted 17.1 per cent of the cases. This figure would be considerably higher if one

included line 5, the brain tumor suspects. This group is represented by those cases which clinically were diagnosed or suspected as being tumors and which did not come to surgery or autopsy. Undoubtedly many of this group of 84 cases would have been found to be tumors but either because of reluctance on the part of the patient to submit to surgery or our unwillingness to perform surgery because of the clinical situation, we were never able to verify this group as brain tumors.

The next largest group is represented by the so-called idiopathic epilepsies. As previously stated, this diagnosis is reserved for a particular group of patients presenting convulsions. It should be here pointed out that the terms convulsions and epilepsy are not synonymous. With the recent development of the electroencephalogram and a more scientific appraisal of the problem of convulsions, it is now established that epilepsy is a distinct entity and that it is just as unscientific to use the term epilepsy in referring to convulsions in general as it is to classify all cardiac pathology under the heading of rheumatic heart disease. This group is represented by those cases presenting a paroxysmal disorder, varying in type between severe motor convulsions, a periodic mental disturbance or a transient visceral disorder. The attacks begin in childhood or early adulthood in 95 per cent of the cases; there may or may not be a definite hereditary tendency and the general neurologic examination between the attacks is negative. These individuals, other than for infrequent psychic deterioration, never show progression and usually the history and electroencephalogram establish the diagnosis.

There are only three other groups in this series which require further comment. One most common cause of convulsions in our notes that birth trauma constitutes the third series. This group was almost entirely made



up of children with whom there is frequently a story of precipitate or prolonged labor, of the application of forceps during delivery or of difficulty in resuscitation. In addition, these children frequently had seizures either immediately or shortly following birth, and one finds that following birth there is a marked irritability or prolonged stupor. Occasionally a bloody spinal fluid had been found on lumbar puncture or a neurologic examination disclosed evidence of hemiplegias, diplegia, strabismus or athetosis. In contrast to this group, the cases of defective development, represented in line 9 of the chart, presented either a normal birth history or they exhibited evidences of prematurity. These children are usually markedly retarded in their development, both mentally and physically. There may be other evidences of congenital defects and the visualization of the cerebral ventricles depicts enlargement of one or more cavities.

The last group in this series which requires further elaboration is the cases represented by line 11 of the chart, the en-

cephalitic group. All too frequently no significance is placed upon the occasional convulsion which may occur during a febrile illness, the statement being made that the convulsion is due to the fever alone, when actually the convulsive seizures may be the only clinical manifestation of an acute encephalitis if spinal fluid studies and careful neurologic examinations are not made. It is our firm conviction, backed by a mass of experimental evidence and post-mortem material, that the convulsions seen in many febrile states are not merely symptomatic and due entirely to the fever alone, but are in reality secondary to the cerebral dysfunction or actual involvement by the agent responsible for the fever. Hyperthermia, in the presence of a normal cortex, will not produce convulsions. While it is true that individuals who have a background of convulsions are prone to exhibit attacks with any febrile upset, the fever is merely a precipitating or aggravating factor and not the etiological agent.

The remaining groups need no further



explanation inasmuch as the diagnosis here is self-explanatory.

What now are the diagnostic measures available in determining the etiology in cases presenting with convulsions? First and foremost is a careful and detailed history. In the younger age group a careful survey of the birth record and the development of the child thereafter. In the adult, precipitating factors and the presence of other symptomatology. In most cases, a careful and detailed history and physical examination will establish the etiologic factor or factors, but in some instances further studies are required. These studies may consist of spinal fluid examination, plain skull films, electroencephalograms, air encephalograms or ventriculograms and, occasionally, arteriograms.

In the first slide presented no attempt was made to divide this group into age periods. For the purpose of comparison and in order to assist us in drawing some conclusions about this entire group, we have compiled another series of 200 cases. This second group of 200 patients with convulsions was compiled from a group of children under age 15. In this series the percentages varied strikingly as to etiology. Here the idiopathic epilepsies lead with 30 per cent, birth injuries constituted the second largest group with 18 per cent, and the encephalitic group represented the third largest with 16 per cent. Tumors and tumor suspects constituted only 5 per cent. In reviewing this series it was readily apparent that in 90 per cent of the individuals the etiological factor was a non-surgical problem and one could safely conclude that in less than 10 per cent of the children under 15 years of age presenting with convulsions, a surgical problem would be encountered. In sharp contrast to this statement is the group of patients over 20 presenting with convulsions. If one investigates the first slide with this in mind, he or

she finds that the bulk of the cases of idiopathic epilepsy, almost all of the birth trauma cases and defective development problems and approximately 90 per cent of the encephalitic group can be discarded, producing a radical change in the percentages. If these cases are discarded and the remainder studied more closely, one finds that the percentage of tumors in this remaining group rises sharply to 27.5 per cent and that there is an additional 11 per cent of cases presenting with surgical problems, such as brain abscesses, posttraumatic convulsive states, vascular anomalies and granulomatous lesions of the brain.

In summing up the problem of convulsions from an etiologic standpoint, one can conclude that in the age group under 20 years the therapeutic problem is largely one of medical management and rather rarely surgical and that the diagnosis of these cases can largely be arrived at by a careful history, physical examination and relatively simple laboratory procedures. In the older age group, however, surgical problems present in over 35 per cent of the cases and require more detailed diagnostic measures to arrive at a diagnosis. One might argue that it is only of academic interest in the younger age group to attempt a fine etiologic diagnosis inasmuch as the medical management of these cases varies so slightly. It must be stressed, however, that this is of prime importance in view of the fact that the prognosis varies markedly depending upon the etiologic factors. In the older age group it behooves the diagnostician to be even more astute in his etiologic diagnosis in view of the fact that therapy varies dependent upon the cause, and maximum improvement cannot be attained unless the correct therapeutic measures are instituted. Lastly, it should be stressed that convulsions are merely symptoms and do not constitute a diagnosis.

## TREATMENT OF EPILEPSY IN CHILDREN WITH SODIUM DILANTIN

BENJAMIN BASHINSKI, M. D.

*Macon*

This report of thirty cases of epilepsy treated by the use of sodium dilantin in connection with a ketogenic diet are patients in my opinion who were suffering from idiopathic epilepsy. Any child with a history of birth injury, head injury, or hemorrhagic disease of the newborn was not included.

We designate epilepsy as a variable complex of symptoms, either as a recurrent or paroxysmal attack of unconsciousness, associated with or without a toxic or clonic muscular spasm. At the present time the cause is uncertain. The seizures may be secondary to some disturbance in cerebral function which may result from structural changes in the brain, to vasomotor changes or a certain state of hydration.

An emotional child will show a *petit mal* type. Some may have malformations.

At times it is rather difficult to distinguish between some behaviorisms and a true *petit mal*.

In our cases the seizures were more common among children with a normal mentality.

Epilepsy has been considered hereditary and epileptics have been discouraged as to marriage. Our small series does not bear out the fact that epilepsy is inherited as a dominant trait.

A careful history in our series has shown that only two cases had any environmental tendency. In one the husband's brother, and the other, the husband's mother and the father's sister.

The age at which the attacks began range from the youngest of one month to the oldest at six years.

The age when examined in the office range from one month to twelve years.

The average attacks were from one to four daily, to as little as one attack monthly.

The majority of the patients gave a history of early morning attacks, or just after bedtime.

Only one seemed to be mentally retarded.

Quite a few of the children were thought to be having fainting attacks, as the head would fall to the side and then an apparent faint, or would be seen to stare when playing or walking.

The blood Wassermann was negative in every case.

One mother had five miscarriages, the first five; and the epileptic was the seventh pregnancy.

The average duration of the attacks after treatment was two months. Five cases responded in one month.

In all cases the seizures were controlled completely with the exception of two. In these two marked improvement was noted as the attacks were less frequent and modified.

In all cases sodium dilantin was used in connection with the ketogenic diet.

It has been our experience that the ketogenic diet alone will not suffice, but without the diet the results are not so striking.

We do know that certain factors influence cell permeability and that alkalosis and superhydration will cause an epileptic to have many more attacks.

We have been taught that any factor that will decrease cell permeability, as acidosis, and to some degree dehydration, will cause fewer attacks.

For these reasons our patient should be



kept on a ketogenic diet for an indefinite period.

Urinalysis should be done every two weeks and an acetone test made at each examination. All patients seem to show a very rapid improvement when acetone is constantly present.

A diet high in fat, and continued until ketosis develops, is very desirable. At the same time keep the water intake low.

Ketonuria remains minimal up to the age of seven to eight months. From then the ability to develop ketonuria increases during the first four years and is supposed to reach a peak at eight years.

Sodium dilantin was used alone in the beginning of our treatment. Very good results were obtained when using the drug alone but a number responded rather slowly until elixir phenobarbital was added to the sodium dilantin. When this method was instituted all but two responded 100 per cent. The same dosage was used in every case, one-half grain three times daily. It is most important that the concentration of the drug be maintained at a constant level.

The drug should never be discontinued abruptly. Our observation has been that in a few cases when the drug was withdrawn suddenly there would follow a greater number of attacks than were noticed originally.

We always advised that sodium dilantin should be given for at least eighteen months after all seizures were controlled.

Sodium dilantin does not cause a soporific effect. In a few of the cases slight toxic manifestations were noted, but were never serious. Even when toxic, symptoms would be controlled by a reduction in dosage. The most common toxic symptom noted was a hyperplasia of the gums causing a sore mouth and tender gums. One child complained of being dizzy. One a dermatitis, coming on the twenty-first day of treatment. For some unexplained cause sodium dilantin seemed to relieve the children with fre-

quent attacks more than those with infrequent attacks.

Sodium diphenylhydantoinate (dilantin) has proven to be the most powerful anti-convulsant tried in the treatment of epilepsy, and when used in connection with a ketogenic diet it has proven to be most gratifying.

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## OBSERVATIONS OF ELECTROENCEPHALIC PATTERNS IN CONVULSIVE DISORDERS OF SUSPECTED ENDOCRINE ORIGIN

### *Preliminary Report*

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ESTELLE P. BOYNTON, M. D.

*Atlanta*

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At the Good Samaritan Clinic, in Atlanta, in the past year two patients presented themselves with complaints of attacks associated with loss of consciousness. Both were married females, each had two living children, and in each the onset of the convulsive disorder coincided with the actual childbearing years. In both patients endocrine investigation led to a diagnosis of pituitary failure following pregnancy, associated with mild hypoestrinism and hypocalcemia. Electroencephalograms proved of interest in the direction of their clinical courses, although treatment at the clinic had been directed at the endocrine dysfunction rather than at the cerebral dysrhythmia.

### *Reports of Cases*

*Case 1*, a married housewife of 35 years (admitted October '44) complained of fainting spells of 2 years duration, occurring from 3 to 5 times daily at intervals of two to three days. Subjective "feelings in the top of her head" followed by weakness of the entire body usually preceded the loss of consciousness. Occipital headache invariably followed these spells. The first seizure occurred while she was visiting her husband in an Army camp, during the third month of her fourth pregnancy. Inasmuch as these complaints had persisted until the husband obtained his release from the service the district nurse who referred her to the clinic was convinced that she was malingering. There had rarely been an eye witness to the seizures. They occurred more often when she was alone with the chil-

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Read before the Medical Association of Georgia, Macon, May 8, 1946.

From the Good Samaritan Clinic, Atlanta.

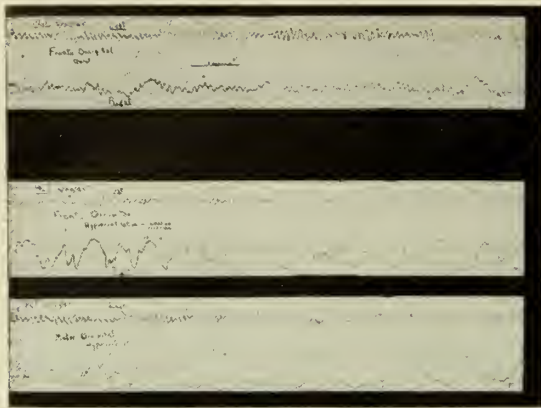


Figure 1  
Electroencephalogram March 30, 1945. Note comment of Case 1.

dren. She resented the burden of caring for the children, and manifested constant anxiety about herself. There was much circumstantial evidence for the inference of a feigned illness.

Electroencephalogram was requested on March 30, 1945. These were done in my office by a two channel Rahm instrument. All the records shown are bipolar leads with comparison of symmetrical areas, right and left. Above you see the fronto-occipital during normal respiration with the eyes closed. The left (top) shows a fairly stable pattern with alpha rhythm of 9 cps. On the right there is evident a baseline swing of 1 cps., with superimposed alpha activity of 9 cps. Comparison of frontomotor and motoroccipital regions with transverse leads localized the abnormal pattern to the right motoroccipital tracing. Immediately upon starting hyperventilation the right F-O (middle strip) showed large slow waves of increased amplitude 120 uv., and 1½ cps., with irregular sharp waves superimposed. The left F-O remained stable with rhythm of 10 cps. and occasional sharpening of fairly regular waves. The motoroccipital leads again confirmed localization with large flat-topped waves of 1 cps., associated with 3 cps., sharper waves.

This record was repeated three days later with similar localization of abnormal function. In view of the possibility that she might have an expanding intracranial lesion rather than neurotic behavior, she was instructed to return at intervals for ophthalmoscopic examinations, and observation without further medication other than phenobarbital grains 1½ daily. Stereoscopic x-rays of the skull were reported negative except for the bridging of the sella turcica previously observed. Subsequently she showed variable incoordination of the left arm and hand, and on one occasion slow nystagmus on conjugate deviation to the left. There was no papilledema. Air studies would have been helpful, but were not available under the wartime conditions. No endocrine therapy was given other than the addition of calcium tablets beyond the dietary intake. In the next eight weeks she began to have paresthesiae in the left leg preceding a seizure. Once the leg became so numb that she had difficulty in walking, and fell on the street. The paresthesiae progressed involving the right hand, mouth, and left thigh. Loss of consciousness was more frequent. Finally a seizure occurred in which the husband reported there was shaking of the flexed left arm. Shortening of the menstrual cycle to 21 days, with prolonged flow of 8 days, occurred. In December '45 she was given estrogens (Breon) 1 cc. intramuscularly twice weekly. Within six weeks the patient reported that she felt better, was less confused and that she was having fewer spells. It was not possible to procure whole pituitary solution at this time due to drug shortage.

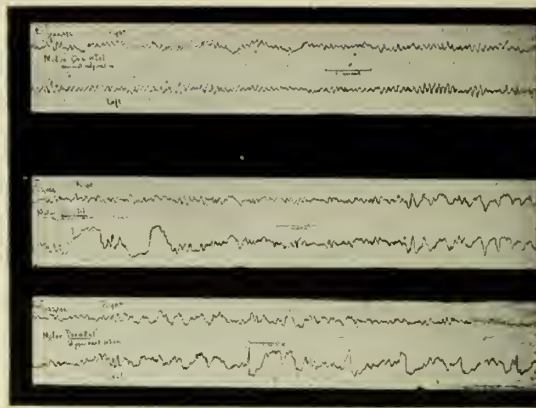


Figure 2  
Electroencephalogram Jan. 22, 1946, Case 1.

Electroencephalogram on Jan. 22, '46 included parietal electrodes. The top line shows the right M-O with mild base line swing. The left M-O is not abnormal under resting conditions. The basic rhythm averages 9 cps., bilaterally. Hyperventilation shows the right M-O irregular, with some 14 cps. and fairly frequent runs of 3 and 4 cps., with sharp waves superimposed. The left M-O shows very large waves of 120 uv. amplitude with additional sharp waves measuring 75 uv. and also 3 and 4 cps., synchronous with those in the right M-O. The motorparietal leads show slow waves varying from 7 to 3 cps., and fast waves averaging 17 cps., on the right. The M-P is asynchronous. There are two spikes and large irregular waves measuring 100 uv., and 1 to 2½ cps.

On March 27, '46 she was started on whole pituitary solution (Armour), 1 cc. three times weekly intramuscularly. She has reported steady clinical improvement with diminished number of seizures, and the menses more normal. She has been able to hold a job as night telephone operator, besides her housework.

This patient still requires air studies, inasmuch as she now recalls having been in an automobile accident with a blow on her head about three weeks before the onset of the first seizure!

Case 2, a 22 year old married woman was admitted (February '45) with the complaint of epilepsy. For 4 years she had been subject to seizures of the *grand mal* type, without warning. She had injured her head several times in falling. She married at 16 years. The first pregnancy was complicated by "kidney trouble," and premature delivery at 8 months. The second pregnancy went to term with normal delivery, although she reported convulsions at each delivery. At the age of 12 years, she recalled injuring the back of her head and neck, when she fell off a see-saw.

The onset of recurrent convulsions was given as 1 year after the first delivery, frequency varied from 5 days to four weeks, and was greatly diminished during the second pregnancy. Since the birth of the second child the seizures had become more frequent and more severe.

EEG taken on March 3, '45 showed dysrhythmia which is diffuse and bilateral but fairly synchronous in the fronto-occipital leads. Larger waves vary from 1½ to 5 cps. There is no regular alpha rhythm evident. The highest frequency is from 7 to 8 cps., on the right (lower tracing). Transverse leads showed large slow waves of 3 cps., and 100 uv. in amplitude, more prominent in frontal and motor regions than in the occipital (which is not included on this slide).

On hyperventilation there are many prolonged par-



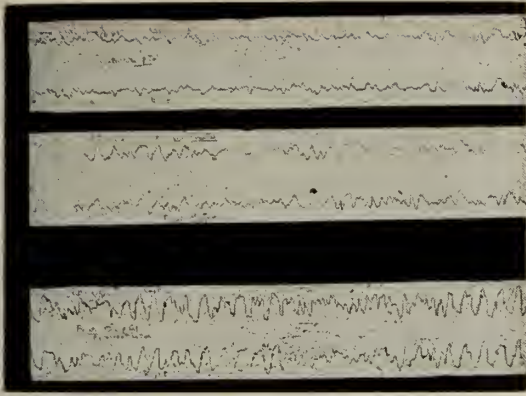


Figure 3  
Electroencephalogram March 3, 1945, Case 2

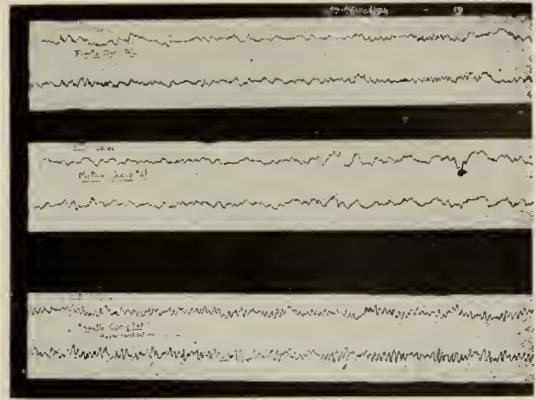


Figure 4  
Electroencephalogram Jan. 28, 1946, Case 2

oxysmal synchronous slow waves of 3 cps., and 100 uv., in both fronto-occipital leads.

The medical impression of "pituitary failure of postpartum type" gave the *grand mal* seizures greater interest because of the apparent coincidence of onset of the conditions in relation to the pregnancies.

The patient was instructed to take 1 cc. whole pituitary substance intramuscularly (Armour's) and to return at monthly intervals. She was taking a proprietary preparation averaging 1 grain of phenobarbital daily.

The frequency of convulsions diminished to a fundamental rhythm of two weeks. The periods of susceptibility were premenstrual and midinterval, conceivably at ovulation date. After three months she was given dilantin, grains  $1\frac{1}{2}$  daily. In June '45 she received news that her husband had been killed in action. Convulsions occurred at weekly intervals for the following four weeks. From August '45 through January '46 there were only three convulsions, occurring in September, October, and January respectively. Each of these seizures seemed to coincide with the probable ovulation date.

Electroencephalogram on Jan. 28, '46 was taken in the postmenstrual week. The F-O leads show bilateral dysrhythmia, with frequencies of 3, 5, and 7 cps., a single run of alpha rhythm of 10 cps., is present. The M-O shows accentuated dysrhythmia with slow waves of 60 to 75 uv., and  $1\frac{1}{2}$  to 3 cps. frequency, accentuated on the right. The small superimposed waves are 10 cps. Hyperventilation was of interest because of the evidence of greater stability. After 2 minutes the F-O appears to have a much more normal rhythm with fairly regular waves of 10 cps., and occasional slow wave of low amplitude. A few large slow waves were noted, but none of the paroxysmal character observed in the record of 9 months preceding. We let her continue to hyperventilate for 11 minutes and obtained a similar record of this.

The patient considered herself improved, and discontinued her pituitary injections but continued to take the dilantin and additional calcium.

In closing we feel that these two individuals serve to remind us of the presence of inter-relations between rhythmic functions of differently organized systems in the body. That the lowered level of pituitary secretion was evidently followed by a lowered threshold to convulsive disorder in

both individuals is a reasonable hypothesis, regardless of the etiologic manifestations of the independent lesions in their central nervous systems.

#### DISCUSSION OF PAPERS OF DRS. HOMER S. SWANSON, BENJAMIN BASHINSKI, AND ESTELLE P. BOYNTON

DR. WM. A. SMITH (Atlanta): We are indebted for these instructive papers dealing with one of the commonest of nervous disorders and one to which too little attention has been given.

There are thousands of these cases in Georgia. New cases at all ages are arising every year.

Dr. Swanson has shown us the great variety of organic diseases of the brain which may result in convulsions, and every effort must be made to diagnose those conditions; even with surgical lesions most all cases will require medical treatment also, and I would like to say a few words about that. These patients need proper psychotherapy. By that I mean they need a proper explanation of the nature of their disorder, the reason why they have to take their medicine, and why they have to take it regularly; otherwise cooperation is lacking and they take their medicine only a short while and then they begin to have attacks again. They have a great many problems on their mind which have to be settled. The old idea that the condition is associated with mental deterioration has to be dispelled. Their worries about marriage and children have to be corrected, and I agree with Dr. Bashinski that convulsive symptoms in both parent and child are extremely rare (about 2 per cent). Unless there is a history of mental disorder or deficiency throughout the family, these patients may marry and have children like anyone else.

In regard to drug treatment, I think that until it is proven otherwise we should assume that every case can be thoroughly controlled. For the convulsions, dilantin and phenobarbital are effective and most patients do better on both drugs at the same time. These should be gradually increased until the attacks are controlled, unless toxic symptoms arise. Too many doctors and druggists tell these patients that phenobarbital is harmful and a "dope" so that they quit taking it. Of course, that is not true. More recently, a new drug, tridione,

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## THE BALANCE OF BIRTHS AND DEATHS IN THE WAR YEARS

World War II has had a more profound effect on population growth in large areas of the globe than has any other war in history, according to the *Statistical Bulletin* of the Metropolitan Life Insurance Company for June, 1946. "The population changes have come about not merely because of the military losses, heavy as they have been. As a matter of fact, the total number of deaths in action in World War II was not very different from that in World War I, while the mortality from disease in all armies dropped materially. The marked difference from previous wars stems from what happened to the civilian populations. The picture varied with the individual countries, and it is one of violent contrast. In the areas under the iron heel of Nazi occupation the major factor was the war which Germany waged against civilians, in accordance with her plan to weaken her neighbors for generations to come. To this end she used mass murder; starvation; the wholesale recruitment of slave labor, with the consequent separation of millions of couples; and many other barbaric measures for which her leaders now stand at the international bar of justice. In other countries more fortunately situated the population changes, in large measure, reflected the effect of the war on the normal course of the birth and death rates.

"From the standpoint of the balance of births and deaths during the war years, our own country presents a highly favorable picture. Because of a spurt in its birth rate and a general decline in its death rate in this period, the United States showed a sizable increase in population over and above its direct military losses. The aggregate increase for the years 1941-1945 was about 7,500,000, or 50 per cent greater than the increase in the five years immediately preceding 1941.

"The situation in England with respect to wartime population growth, although different from ours in many respects, has been quite satisfactory. In the period 1939-1945 England actually added about 700,000 to her population through the excess of births over deaths. This is a net figure and allows for the military losses and for the deaths of 60,000 civilians in air raids. Births during the war years were about 200,000 in excess of the number expected on the basis of prewar rates. During the later war

years particularly, births in England rose to the highest level in nearly a generation. This increase in births went a long way to counterbalance, numerically at least, the deaths resulting from the war. In every war year, with perhaps one exception, births exceeded the total of deaths, both civilian and military. In 1944 the excess was nearly double the annual average in the prewar period 1932-1938.

"Germany presents a very different picture. In the years immediately preceding the war there was a rise in the birth rate, largely as a result of the increase in employment incidental to Germany's huge rearmament program, and also because of official measures to promote larger families. The war brought this upswing in births to an end, and as against a natural increase (excess of births over deaths) of nearly 3,000,000 in the prewar years 1932-1938, there was a deficit of perhaps as great an amount in the war period, 1939-1945. In the early years of the war the Germans managed to keep their birth rate at a fairly high level, while their death rate, including military deaths, rose only moderately. The consequence was a substantial excess of births over deaths. In 1942, however, the tide turned. Even though health conditions in the civilian population remained relatively good until near the end of the war, the combined effect of the sharp decline in the birth rate, the heavy military losses, and the civilian deaths from bombing was to produce a rapidly accelerating population deficit. For the war period as a whole this deficit was probably twice that for World War I.

"As a result of the contrasting war-time trends in the birth rates for Germany and England, the positions of the two countries became reversed. In 1939 the birthrate for Germany—20.4 per 1,000 population—was substantially higher than that for England—namely, 14.9 per 1,000. By 1944 the rate in Germany had dropped to near 14, while England's had risen to 17.5.

"France, too, had an unfavorable balance of births in relation to deaths, but in her case the factors were different from those operating among other major belligerents. French military losses in World War II were only a fraction of her losses in World War I. The population deficit in France rose primarily out of the marked fall in the birth rate. Three major factors account for this decline: The retention of about 1,500,000 young Frenchmen in prisoner-of-war camps in Germany, the recruiting of French labor for work in Germany, and the lack of food to maintain the population in good physical condition. The last factor also accounts for a sizable increase in the death rate and a particularly sharp rise in infant mortality. Deaths in France, including those in her armed forces, exceeded births by about 750,000 for the war period as a whole. Strangely enough, the comparison with prewar years is not too unfavor-



able, since even before the war deaths in France had already exceeded the number of births. The population deficit in France incurred during World War II was much less than for World War I, when the deficiency amounted to about 3,000,000.

"For countries like Russia, Poland, Yugoslavia, and Greece the data are so fragmentary that they cannot be woven into a consistent story. Against these nations the Nazis unleashed the full force of their brutality, and these unfortunate peoples suffered so much unrecorded destruction of life that the facts will probably never be known with any degree of accuracy.

"The immediate effects of the war on population growth are only part of the picture. The impact in many countries will be felt for generations to come. This holds true particularly for those countries which suffered the heaviest losses of young men and which experienced the most severe reduction in birth rates."

### TYPHOID DEATH RATE DECLINING STEADILY IN LARGE U. S. CITIES

*Number of Cities With No Deaths Increased  
From 50 in 1942 to 56 in 1945  
Report Reveals*

Typhoid fever deaths in 93 large U. S. cities for which data are available have shown a steady decline since 1942 when the last report was made, according to the 32d annual report appearing in the July 6 issue of *The Journal of the American Medical Association*. In 1942 there were 95 deaths, 85 in 1943, 73 in 1944, with a slight increase, 87 in 1945. The death rate from typhoid per hundred thousand of population for the same period was 0.25 in 1942, 0.22 in 1943, 0.19 in 1944 and 0.23 in 1945.

In the 78 cities for which data have been available since 1910, the report says, there occurred 83 deaths from typhoid in 1942, 78 in 1943, 66 in 1944, and 80 in 1945. The year 1944 is the lowest on record of typhoid deaths. It was estimated that the death rate per hundred thousand of population for this period was 0.22 in 1943, 0.18 in 1944 and 0.22 in 1945 as compared to 0.23 in 1942 and 0.34 in 1941.

Figures for the report were obtained from local health officers, who were asked to record an estimate of population for each of the three years. "It is recognized," the report says, "that in areas of concentration of military and industrial activities a slight error will result, and some city and group rates may be a little too high and even too low."

"The number of cities with no typhoid death during the past two or more years has increased from 31 in 1942 to 41 in 1945," the report

points out. Fort Wayne continues to head the list with no death in 11 years. South Bend, with an excellent record of no death for eight years, recorded one among nonresidents in 1944. However, this city reports no typhoid death among residents for 10 years. Fall River and Lynn report no death in nine years. Cambridge no death in eight years."

The number of cities with no death from typhoid has increased from 50 in 1942 to 56 in 1945. Two of the three cities (Charlotte, Gary) not included in the 93 also report no death. Forty cities (41 with Gary) record no typhoid death in 1944 and 1945. When corrected for residents there remain no cities with rates of 2.0 or more. The number of cities with rates of less than 1.0 has increased by three (87 in 1945, 84 in 1942).

The New England cities with a population of 2,579,152, which have usually reported the lowest group rate, trailed the East North Central cities (0.07) by a narrow margin (0.08). "The lowest group rate thus far attained (0.04) was recorded by the New England cities in 1944 with but one death from typhoid," the article states. "In 1945 there were but two deaths, one each in Boston and in New Bedford. This marks the first death in the latter city for nine years. Twelve of the New England cities (there were 11 in 1942, 10 in 1943, 13 in 1944) report no death from typhoid in 1945. While in 1940 one half of the 18 cities recording no deaths from typhoid during a two year period were to be found among the New England cities, in 1945 one fourth (11 among 41) were in this group."

Thirteen of the large Middle Atlantic cities (there were eight in 1941, 11 in 1942, 15 in 1943, 11 in 1944) report no death from typhoid in 1945. The Middle Atlantic cities have a group rate (0.23) which is higher than that of the East North Central, New England, West North Central and Mountain and Pacific cities. It marks the highest rate for these cities since 1941, when it was 0.24, the report reveals. Lower rates were recorded for 1942 (0.15), 1943 (0.08) and 1944 (0.17). Five cities (Albany, Erie, Scranton, Trenton, Yonkers) record no death during the five year period 1941-1945.

The rate (0.62) for the South Atlantic cities (population 2,727,985) is higher than the rate of 1944 (0.22) and that of 1943 (0.29) but slightly lower than that of 1942 (0.70). In these cities there occurred 17 deaths in 1945, six in 1944, eight in 1943 and 19 in 1942.

The East North Central cities (population 9,386,378) have regained first place, which rank they held in 1941 and back in 1938. Thirteen (12 exclusive of Gary) of the cities in this group (Akron, Canton, Cleveland, Evansville, Flint, Fort Wayne, Gary, Grand Rapids, Milwaukee, Peoria, South Bend, Toledo, Youngstown) report no death from typhoid in 1945. In this

geographic section there occurred seven deaths in 1945, 13 in 1944, 24 in 1943 and 13 in 1942. Detroit recorded no death among residents in 1942, again in 1945. "The increase in deaths in this group of cities in 1943 was due primarily to a high incidence of the disease in Toledo," according to *The Journal* article, "13 of the 24 deaths occurring there. Chicago reports but a single death for each of the three years 1943-1945.

The six cities in the East South Central group (population 1,286,747) show a definite increase in the death rate (0.70 in 1945, 0.31 in 1944, 0.62 in 1943, 0.54 in 1942). This group has the highest rate for 1945, the West South Central cities being next (0.59).

The West North Central cities (population 2,716,484) maintain their consistently low rate (0.11 for each of the past three years, 1943-1945). Six cities record no death in 1945. There were seven such cities in 1944, seven in 1943 and five in 1942.

The eight cities of the West South Central group (population 2,048,692) report a continued reduction in the rate and establish a new low rate of 0.59 for the group. In these cities there occurred 12 deaths in 1945, 19 in 1944 (rate 0.93), 17 in 1943 (rate 0.83), and 15 in 1942 (rate 0.73). Three cities (El Paso, Oklahoma City, Tulsa) record no death in 1945.

The 11 cities (excluding Sacramento) in the Mountain and Pacific states (population 4,186,039) report a decrease from 16 deaths in 1941 (rate 0.38) to 13 in 1942 (rate 0.31), to eight in 1943 (rate 0.19), and to five in 1944 (rate 0.12) and an increase to seven in 1945 (rate 0.17). This group stands in fourth place in 1945. Eight of these cities report no death from typhoid in 1945. There were nine such cities in 1944, seven in 1943 and seven in 1942.

In conclusion the article states: "For 1941-1945 the rate for the New England cities (0.14) marks a distinctly new record and is followed by the East North Central and West North Central Cities (0.16) and the Middle Atlantic cities (0.17). The reduction in rates for all groups by five year periods is most impressive. For 1945 the health officers report no special outbreaks of typhoid. Improvement has been general throughout the country, and the war years do not appear to have contributed materially to the typhoid problem in our large cities."

#### BERIBERI HEART DISEASE TEST OFFERED AFTER 5-YEAR STUDY

Four physicians who made a five year study of beriberi heart disease at the Cincinnati General Hospital offer a new set of standards to aid in differentiating it from other types of heart disease which it closely resembles.

Writing in the June 29 issue of *The Journal of the American Medical Association*, the doctors—M. A. Blankenhorn, C. F. Vilter, I. M. Scheinker, and R. S. Austin, from the Departments of Internal Medicine,

Neuropathology and Pathology, University of Cincinnati College of Medicine—recommend applying the following test:

(1) There must be insufficient evidence for any other cause; (2) a thiamine (vitamin B<sub>1</sub>) deficient diet must have elisted for three or more months; (3) signs of nerve inflammation or of pellagra, another vitamin deficiency disease, must be present; (4) detection of an enlarged heart with normal heart rhythm; (5) presence of swelling; (6) high blood pressure; (7) minor electrocardiographic changes and (8) recovery with decrease in heart size or autopsy consistent with beriberi heart disease.

Beriberi is usually caused by a thiamine deficiency in the diet. It is prevalent chiefly in Japan, India, China, the Philippines and the Malay Peninsula. The disease is marked by spasmodic rigidity of the lower limbs, with a wasting of muscular tissue, paralysis, anemia and neuralgic pains.

During the five year study which the doctors began in 1940, they were able to recognize 12 cases of beriberi heart disease which conformed to the eight-point criteria which they recommend. Because the disease was first recognized in its late stages, five of the patients died in the hospital while one died after returning home. Rest and injections of large doses of thiamine were the mode of treatment.

Dietary deficiency, which was found in 11 patients, was directly ascribable to alcoholism, according to the article. "The majority of the diets, as far as assessment was possible, were deficient not only in thiamine but also in the other water soluble vitamins, particularly niacin, riboflavin and ascorbic acid. One patient, though an alcoholic addict, had apparently been eating amounts of the essential nutrients which under normal conditions would have been adequate. This person, however, proved to absorb many substances poorly. In every instance the patient had been existing on a diet deficient in thiamine for longer than three months."

In all 12 patients there was other evidence of nutritive failure, state the authors. Always there was some indication that the nerves near the surface of the skin were inflamed or that pellagra was present. In half of the patients both disorders were found. Eight of the 12 patients had anemia; nine were found to have an abnormally decreased amount of protein in their blood plasma. In addition x-rays revealed an enlarged heart in 10 of the patients.

#### ATABRINE TEMPORARILY GIVES NAILS YELLOW FLUORESCENCE

*Special Light Shows That Patients Retain Atabrine in Nails for About One Year After Treatment Is Stopped*

Two groups of investigators report in the July 6 issue of *The Journal of the American Medical Association* that they noted under a special kind of light a greenish yellow fluorescence of the nails of patients treated with the antimalarial drug atabrine.

One group consists of Julius E. Ginsberg, M. D., Assistant Professor, Department of Dermatology, Northwestern University Medical School, Chicago, and Col. Paul L. Shallenberger, Chief of Medical Service, Gardiner Hospital, and an Instructor in the Department of Medicine at N. Y. Medical School.

Drs. Ginsberg and Shallenberger observed at the Gardiner General Hospital 511 patients, 158 of whom had been taking atabrine. No unusual fluorescence was seen among the 353 who had no atabrine medication but 79 of those who had taken the drug showed this greenish yellow fluorescence.

The unusual fluorescence was detected under Wood's light. This light is passed through a filter which eliminates the visible rays and has fluorescent exciting properties. It is used in the diagnosis of skin disease.

These authors noted that: "Patients still on atabrine



antimalarial prophylaxis or those on atabrine therapy showed the characteristic greenish yellow fluorescence of all the nails under Wood's light all the way to the cuticle.

"Atabrine fluorescence usually did not disappear from all nails until about one year after the drug was stopped.

"Subjects who had taken only small quantities of atabrine did not show the characteristic atabrine fluorescence phenomena."

Atabrine when given by mouth accumulates in the tissues and is slowly excreted from the body. Even when its use is discontinued, excretion continues for long periods. Although these facts are known, the authors state that "there appears to be, at least from the point of view of fluorescence in the fingernails and toenails, a longer delay in complete body excretion of atabrine than previously reported."

The second group of investigators includes: Robert R. Kierland, M. D., from the Section on Dermatology and Syphilology, Mayo Clinic, Charles Sheard, Ph.D., from the Division of Physics and Biophysical Research, Harold L. Mason, Ph.D., Division of Biochemistry, Mayo Foundation, and Walter C. Lobitz, M. D., from the Section on Dermatology and Syphilology, Mayo Clinic, Rochester, Minn.

Dr. Kierland first noticed this greenish yellow fluorescence of his own nails while he was examining a patient under the Wood light. He had just returned from the Southwest Pacific where he had been taking atabrine in daily doses for almost two years.

"Since then an additional nine persons have shown this fluorescence," the article states. "All of them had taken atabrine from five to 21 months. In no person not receiving atabrine has this fluorescence been observed. Under ordinary day and night light all nails appeared normal."

#### SUBSTANCES PLACED ON BODY SURFACE NEED MORE STUDY, JOURNAL SAYS

Referring to cases of poisoning associated with the use of thioglycolic acid in the so-called cold wave process for permanent waving of the hair, the June 29 issue of *The Journal of the American Medical Association* says editorially that "as much careful evidence needs to be accumulated regarding the safety of substances placed on the surface of the body as those taken into its interior before these processes are released for use to the general public."

The statement was made in connection with an article in which Carey P. McCord, M. D., of Detroit, called attention to certain facts which he believed were overlooked by Lawrence H. Cotter, M. D., of New York, in his discussion of the cold wave process in *The Journal* of June 15. Dr. McCord believes that damage to the liver by the use of cold wave chemicals has not yet been definitely shown in any instance and that allergic responses are infrequent when materials used are properly prepared.

"Notwithstanding these statements," the latest issue of *The Journal* says, "the fact remains that some 50 different commercial agencies are engaged in the manufacture of materials used in cold wave processes, that there exist no definite standards as to what is safe or harmful, that experimentation before launching such products is for the most part inadequate and incomplete and that it is time for public recognition of the fact that as much careful evidence needs to be accumulated regarding the safety of substances placed on the surface of the body as those taken into its interior before these preparations are released for use to the general public."

Have you renewed your subscription to *The Journal of the American Medical Association* for 1946?

## LEAD PENCIL IN ILEUM

### Report of Case

M. W. ANDERSON, M. D.  
*Social Circle*

On July 22, 1946, both tubes and a lemon sized cyst of the right ovary were removed from a colored female twenty-four years of age. On exploring after the abdomen was opened a pencil was found lying free in the lumen of the ileum. It was identified as a pencil because the red rubber eraser could be seen through the thin intestinal wall. The distance between the pencil and the cecum was not determined. It was removed through a short longitudinal incision, the tubes and cyst were removed, and the abdomen was closed without drainage.

The pencil was an ordinary lead pencil, six and eleven sixteenths inches long; its quarter inch lead point was rather dull; the eraser was worn down even with the metal collar; the paint was unchanged but the lettering was practically obliterated; and through dissolution of the glue the two wooden halves were slightly separated.

The following is a composite of history given by the patient and data given by the physician who referred her to me: On October 19, 1945, the patient attempted to pass the pencil into the uterus to produce abortion. When it was inserted almost full length it met with considerable resistance; but with a firm push, and with some pain, the pencil was passed so far that it could not be removed. In two hours cramping pains began in the lower abdomen and there was slight vaginal hemorrhage. The pains increased in severity and the patient was hospitalized on October 21. A four months fetus was aborted nine days after the pencil was inserted. Her total stay in the hospital was ten days.

She was ill again around "Christmas time" and received medical care at home for three weeks. Her complaint then was lower abdominal pain.

She was ill again for one week in April or May, 1946 with pains in the lower abdomen and in the region of the appendix.

She was admitted to the hospital on July 2, 1946, and discharged three days later. Her complaint was pain at the anterior superior spine of the right ilium, extending backward to the lumbar spine.

She was admitted to the hospital again on July 19, 1946, when I saw her and operation was decided upon. The tentative diagnosis was salpingitis. She complained of pain in the lower abdomen and also of pain extending from the right ilium to the lumbar spine. Abdominal palpation and vaginal examination were unsatisfactory because of rigidity.

Her condition now, one week after operation, is entirely satisfactory.

#### TWO THOUSAND TO ATTEND COLLEGE OF SURGEONS' ASSEMBLY

More than 2000 surgeons and other doctors of medicine are expected to attend the three-day assembly of the United States Chapter International College of Surgeons in Detroit, October 21-23, 1946.

Among the principal speakers to be heard in Detroit's Masonic Temple will be Mr. Hamilton Bailey of London, England; Dr. Francisco Graná of Peru; Dr. Felipe F. Carranza of Argentina; Dr. Manuel Manzanilla of Mexico; Dr. Wayne Babcock of Philadelphia, and many other leading surgeons of the United States.

Dr. Herbert Acuff of Knoxville, Tennessee, is president and Dr. Custis Lee Hall of Washington, D. C., is president-elect of the U. S. Chapter, International College of Surgeons. Detailed information and copy of the program may be obtained by writing L. J. Garipey, M. D., 16401 Grand River Avenue, Detroit 27, Michigan.

# CANCER OF THE CERVIX AMONG STATE-AID PATIENTS

W. J. MURPHY, M.D.  
Atlanta

*Director, Cancer Control Service,  
Georgia Department of Public Health*

Among patients reporting to the Georgia State-aid Clinics, cancer of the cervix ranks second to skin cancer in the number of malignancies observed. During the period of November, 1937 through December, 1945 a total of 1444 patients with cancer of the cervix reported to the clinics. Of these, 725 were white and 719 were colored patients. Among white females, cancer of the cervix accounted for 23 per cent of all malignancies observed, while in colored females the corresponding figure was approximately 50 per cent.

When treated early, cancer of the cervix is one of the most curable malignant lesions. Estimates of curability commonly range from 75 to 80 per cent. Considering the frequency with which cervical cancer is observed together with the possibilities for cure, it is apparent that early detection and treatment offer an opportunity for the saving of many lives.

Education of the laity with respect to the early symptoms of cancer is a basic part of the control program. These activities are carried on with a view to inducing patients to report for examination as soon as symptoms appear. Although the effectiveness of this program may not be fully apparent for many years, some indications of success are evident at this time.

In cancer of the cervix it is usually possible to obtain from the patient a fairly reliable history as to the duration of symptoms prior to the date of examination. If many such histories are considered, the average duration of symptoms during successive periods of time should provide some indication as to whether patients are now reporting earlier than in the past. In the table here shown is the average duration of symptoms among state-aid patients with cancer of the cervix. The results during three successive time periods are compared, the figures showing the average interval in months between the onset of symptoms and the date of report to the clinic.

## *Duration of Symptoms Prior to Examination Patients With Cancer of the Cervix*

<i>Time period</i>	<i>White</i>	<i>Colored</i>
1937 - 39	10.5 months	8.8 months
1940 - 42	8.1 months	7.6 months
1943 - 45	6.9 months	7.5 months

Among white patients with cancer of the cervix there has occurred a gradual decline in the time interval between the onset of symptoms and the date of examination. This is a definite indi-

cation that a larger proportion of these patients are now reporting during the early stages of the disease. Among colored patients, however, the decline is comparatively small and it seems unlikely that much progress has been made toward earlier reporting in this group.

It will be noted that during the early years of the program the average duration of symptoms in the colored group was less than in the white. During that same period, however, clinic reports indicated a greater proportion of advanced lesions among colored patients. The shorter time interval for the colored group is probably the result of less reliable histories although it could be due to more rapid progress of the disease.

During the years 1937-39 the long delay between the onset of symptoms and the beginning of treatment obviously indicates that a high proportion of the patients reported with advanced lesions. This is reflected in the cure rate. Of all patients with cancer of the cervix who reported to the clinics during that period, approximately 20 per cent were living and well five years later. In view of the fact that during succeeding years white patients reported earlier in the course of the disease, one might reasonably expect an appreciable rise in the cure rate during the later years of the program.

Education of the laity is apparently having a beneficial effect in persuading patients with cancer of the cervix to report for examination earlier in the course of the disease. Obviously, such efforts should be expanded until the early symptoms of cancer are familiar to everyone. At the same time, efforts directed toward the detection of early cervical cancer in apparently healthy women would add materially to the effectiveness of the program. The routine examination of apparently healthy women has frequently discovered early cancers of the cervix before they had given rise to symptoms. Obviously, the periodic examination of women of middle age and beyond offers an important means for early case finding. Similarly, the use of the vaginal smear in apparently healthy women will undoubtedly prove an important method for the early detection of cervical lesions.

State-aid patients come largely from rural areas and are difficult to reach through educational efforts. Nevertheless, among white women there appears to be a definite trend toward earlier case finding. Considering the frequency with which cervical cancer is encountered together with the curability of early cases, this trend should eventually be reflected in the number of 5-year cures obtained. At the same time, the more widespread employment of periodic medical examinations and the use of the vaginal smear where practicable would also affect the cure rate by adding materially to the number of early cases coming for treatment.



## GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1008 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, WALnut 8911; residence, JACKson 7979.

### THE PATIENT FIRST

MRS. PAULINE COX, R. N.

*Second Vice-Chairman*

*Private Duty Section, G. S. N. A.*

*The patient first* and his or her well being is the key to the meaning of good private duty nursing.

It goes without saying this cannot be without the cooperative, loyal attitude on the part of the nurse toward the attending physician. The nurse can help her patient immeasurably by her respectful attitude toward the physician of her *patient's choosing*. Not to mention ethics that do or should exist between the two professions.

By virtue of her close contact as well as the constant service she renders, it is her responsibility to keep alive the meaning of the Florence Nightingale pledge, ever demonstrating its true meaning by following her example in service.

Private duty nursing has long been scoffed at by a few pitiful souls (both in and out of the profession) who have an exaggerated complex of self-importance. While this has been going on the private duty nurse has continued with pride her mission in life—using all her theoretical knowledge plus experience to do a good task in bedside nursing.

Pressure is being used in nursing today to intimidate those nurses who do not have degrees or are in the process of obtaining them. Ability as a nurse is given little consideration. But are we not losing sight of the real need in nursing—the actual performance of the task the name implies. It has been my observation that nurses with degrees do not do actual nursing. Are all registered nurses to be supervisors or teachers—leaving the care of the ill to the unskilled hands of practical nurses and subsidiary workers? If registered nurses of today do not answer the urgent call of today the hospitals will be forced to use these unskilled workers. The patient has to be cared for now. His needs will not wait. No sensible person opposes additional education, but to assume the attitude that a registered

nurse is a liability in the profession unless she is working toward a degree is false. This type of attitude reflects on the intelligence of the person who holds with such an idea. It has contributed much to the hesitation of the available nurse in answering the urgent call for more nurses in hospitals *now*.

The good private duty nurse learns something new that is of benefit to her patient and herself every day, but she stays on the job. She sometimes dreams of a degree, but she knows that her place is in the sick room rather than in the classroom. Certainly it is until this great emergency is over.

There is no place or excuse in any field of nursing for either snobbery, condescension or intolerance.

The challenge to the private duty nurse is not in more college credits, but rather in the fitness of being able to administer to, or encourage by example, the spiritual well-being of her patient. By that *it is not meant* to enter into *discussions of religion or creeds or medical treatment* with her patient.

No group has so magnificent an opportunity of being able to aid in this part of the patient's recovery. It is a conceded fact that a recovery, or even lifting of one's spiritual self, goes a long way in aiding a physical recovery. Many illnesses are rooted in a sick soul. Helping to ferret out the cause of symptoms or diseases of man is an incomplete task, if while doing so we forget the reason for man's existence and his place in the world.

In conclusion, quoting another nurse who has expressed the true ideals of nursing, "The nurse can realize with perfect truth that she, in a world of misty ideas and even hate, practice splendidly Christ-like love. She stands as a messenger of healing with hands singularly like the hands of Mary herself. If the Lord said, "Thou shalt love thy neighbor as thyself," she does. If He said that a cup of cold water given in His name was of infinite value, she spends her entire nursing day holding cups of tenderness to the lips of God's sick.

DISCUSSION OF PAPERS OF DRS. HOMER S.  
SWANSON, BENJAMIN BASHINSKI, AND  
ESTELLE P. BOYNTON

(Continued from Page 231)

is available for control of *petit mal* attacks, and its effect is often amazing; children who have 50 to 100 attacks a day have been completely freed of them in a short time.

I want to congratulate Dr. Bashinski on the use of the ketogenic diet. It is often effective but tedious, for both the doctor and the patient. Other than a true ketogenic diet there is no special diet of value. These patients must be advised to avoid alcohol and avoid loss of sleep. Some patients will have attacks only under those conditions.

There are a great many social aspects to this disease which should receive attention. It is unfortunate that Georgia has no institution for those few cases whose attacks cannot be controlled and where they could be taught a trade, be made self-supporting. Some attention should be given to the problem of a driver's license, which should be denied these patients.

U. S. P. BOARD OF TRUSTEES MEETS

The U. S. P. Board of Trustees recently met for the first time at the new U. S. P. headquarters at 4733 Kingessing Avenue, Philadelphia. During the past year, the U. S. P. office was moved in its entirety from the space which it had occupied at the Philadelphia College of Pharmacy and Science, to a place of its own where greater opportunity is provided for its many activities. The board re-elected Robert L. Swain, of New York City, and Adley B. Nichols, of Philadelphia, as chairman and secretary, respectively, for the coming year.

Plans were made looking to the appearance of the U. S. P. XIII before the close of the year, and to the development of a comprehensive program upon which to base admissions for the following revision, the U. S. P. XIV.

Consideration is again being given to having the U. S. P. XIII translated into Spanish and published for use in Cuba, the Philippines, and many of the South and Central American countries. The Spanish edition of the U. S. P. is now recognized as the official pharmacopoeia of a number of these countries and others are considering similar adoption.

The board adopted the following extract from revision chairman Cook's annual report and asked that it be issued as an expression from the board:

"The strain of the war and the intensive living forced upon many persons who accept responsibility has again left its mark upon our pharmacopoeial group. Since the last meeting of the board, two members, Leonard A. Seltzer and Carl L. A. Schmidt, have died. We have also lost, by death, two of the most active workers on our advisory boards, Dr. H. O. Calvery and Dr. A. C. Hunter, both of the Food and Drug Administration. All of these made important contributions to the U. S. P. XIII, and Dr. Calvery's interest, constructive suggestions, and practical help had much to do with the establishing of our present creditable reference standard program, helping it to meet fully the needs of the enforcement officials from a legal standpoint. All of these good friends are sorely missed."

NEWS ITEMS

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, July 11. Program: Case Report from Piedmont Hospital, "Cerebral Granuloma Due to Schistosomiasis," Dr. Homer Swanson and Dr. E. F. Fincher. Clinical Talk, "Clinical Significance of Involutional Melancholia," Dr. John D. Campbell. Paper, "Psychotherapy and General Practice," Dr. R. S. Leadingham. Discussion: Dr. Charles F. Stone, Jr., and Dr. Lawrence F. Woolley.

The Navy is maintaining a Naval Air Reserve Station at Atlanta, for the purpose of keeping in training naval reserve aviators who are now on inactive duty. The plan in effect is the organization of aircraft carrier groups, patrol bomber groups, fighter groups, etc. These groups report at the Naval Air Station for one day active duty (usually on Saturday or Sunday) twice a month. Each group is to have two physicians, one of whom is a flight surgeon.

The Southern Medical Association annual meeting will open at noon on Monday, November 4, Miami, Fla., the scientific sessions beginning at 2:00 p. m. and will continue through Thursday afternoon, November 7. The general headquarters (registration information, etc.), scientific, hobby and technical exhibits and some sessions will be at the Municipal Auditorium in Bayfront Park on Biscayne Boulevard. The remainder of the scientific sessions will be in the bayfront hotels near the Auditorium. The five principal bayfront hotels on Biscayne Boulevard are: McAllister, Columbus, Colonial, Everglades and Alcazar. Reservations will be made directly with the hotel of one's choice. When that hotel has reserved all the rooms it has, the request will be turned over to the Hotel Committee and reservation made by the committee at another hotel.

Dr. W. A. Coleman, Eastman, founder of Coleman Sanatorium, and widely known physician and surgeon, was, on June 3, highly honored during Mercer University commencement exercises, when he was presented the Algernon Sydney Sullivan award of the Southern Society of New York. The award is in recognition of Dr. Coleman's outstanding civic achievements, and notable services to his state and community.

Dr. J. F. Covington, formerly of Monroe, announces the opening of his office for the practice of medicine at East Point Pharmacy Building, East Point.

Dr. Ralph J. Davis, Rome, recently released from the Medical Corps of the United States Army has resumed the practice of medicine and surgery at 429½ Broad Street, Rome.

Dr. Dan Duggan, Sandersville, announces his return from the United States Navy and is now associated with Rawlings Sanitarium, Sandersville. Other physicians connected with Rawlings 55-bed institution are: Dr. Fred Rawlings, Dr. O. D. Leonard and Dr. William Rawlings, who also recently received his discharge from military service. Sandersville now has nine practicing physicians.

Dr. Bon M. Durham, a native of Commerce, announces his release from active duty in the United States Army Medical Corps and the opening of his office at 205 South Lee Street, Americus, for the practice of internal medicine.

Dr. Daniel C. Elkin and Dr. John D. Martin, both of Atlanta, have been appointed consultants in surgery to the Surgeon General of the Army. Along with 72 others they will seek to "improve wherever possible the quality of medical care given the American soldier," Maj. General Norman T. Kirk, the surgeon general announced. Dr. Elkin is on the faculty at Emory University, and Dr. Martin is a staff member at the Emory Hospital. Other appointees, all of Augusta and of the



faculty of the University of Georgia School of Medicine include: Dr. W. Eugene Matthews, otolaryngology; Dr. J. Robert Rinker, urology; Dr. John H. Sherman, general surgery; Dr. Perry P. Volpitto, anesthesia, and Dr. Virgil P. Sydenstricker, internal medicine.

Dr. Edgar Hill Greene, Atlanta, a past president of the Fulton County Medical Society and a member of the staffs of Emory and Grady hospitals, has received a citation for his work during the war as chairman of a committee for procurement and assignment for physicians, dentists and veterinarians for the Fourth Service Command. The citation was signed by President Truman, Norman T. Kirk, Surgeon General of the Army; Ross T. McIntire, Surgeon General of the Navy, and Thomas Parran, Surgeon General of the U. S. Public Health Service. The engraved certificate cited Dr. Greene for serving "with diligence and determination in the interests of meeting both military and civilian needs."

Dr. Charles C. Harrold, Macon, resigned as chief of the cancer service of the Macon Hospital in a recent letter he sent to the Board of County Commissioners. Dr. Harrold recommended that Dr. Thomas Harrold, Jr., formerly his assistant, be named as his successor. The retiring chief said he was stepping down because of his age. He has been with the Macon Hospital staff since 1904, except for a short time when he was with the armed forces.

Dr. Thoms S. Harbin, Rome, announces the opening of his offices at the Harbin Hospital, Rome. Practice limited to diseases of the eye, ear, nose and throat.

Dr. Frank K. Boland, Atlanta, recently received a letter from Major General Norman T. Kirk giving the following information: "The Medical Corps reached its peak strength of 47,000 physicians in the fall of 1945. Of that number over 2 per cent were in the Regular Army. Approximately 170 Medical Corps officers were killed in action or died of wounds."

Also a report from Admiral Ross McIntire of the Navy, in which he said: "The peak strength of the Regular Navy Medical Corps during World War II reached 2,136, while the Naval Reserve reached a peak of 11,728, including 55 female physicians."

"The mortality figures for the Regular Medical Corps during this period reveal a total of 41 killed in action, and 29 meeting their death for various causes, but not the result of enemy action. The corresponding figures for the Naval Reserve show a total of 85 medical officers killed in action and a total of 83 deaths for other causes, not enemy action."

Dr. Frank Eskridge, Jr., Atlanta, on return from services in the United States Navy, announces the opening of his office at 744 West Peachtree Street, N. W., Atlanta.

Dr. J. E. Morris, Douglas, formerly of Moultrie, was recently appointed as public health officer for Coffee, Atkinson and Berrien counties. Dr. Morris, who will spend half of his time in Coffee, 30 per cent in Berrien, and 20 per cent in Atkinson, states that he plans to begin a spinal tap clinic in Douglas soon to eliminate the expense and inconvenience of transporting patients to Savannah and Augusta.

Dr. Weems R. Pennington, formerly of Matthews, recently released from the Army Medical Corps as flight surgeon in the Army Air Forces, announces the opening of his offices in the new Hotel Lincoln Building, Lincolnton, for the practice of medicine.

Dr. C. W. Roberts, Atlanta, was elected to the board of trustees of the American Medical Association at the recent meeting in San Francisco. The association's new president, Dr. Olin West, Chicago, who resigned recently as A. M. A. secretary and general manager, received a

standing ovation when he attacked persons who claimed that a "hierarchy" controlled the national medical body. "Those chosen to office in the A. M. A. are concerned primarily with one direct effort—that of directing and carrying out the policies formulated by the house of delegates," Dr. West said.

The Southern Psychiatric Association will hold its annual session at the Jefferson Hotel in Richmond October 7 and 8. The officers of the association are: Whitman C. McConnell, M. D., St. Petersburg, Fla., president; James K. Hall, M. D., Richmond, Va., president-elect; Edmund McC. Connelly, M. D., New Orleans, La., vice president; Arthur J. Schwenkenberg, M. D., Dallas, Tex., councilor; John S. Hickman, M. D., Meridian, Miss., councilor; Newdigate M. Owensby, M. D., Atlanta, Ga., secretary-treasurer.

The Bibb County Medical Society held its regular meeting at Dixon's Lodge, Macon, July 9. The members were entertained at a barbecue.

Dr. Arthur G. Singer, formerly of Philadelphia, Pa., announces his association with Dr. W. H. Good, Toccoa, for the practice of medicine.

Dr. W. D. Travis, Covington, for many years one of the most prominent physicians of Newton County, who has been confined to his home for a number of weeks due to an automobile accident, is able to be out and is attending to his many duties.

Dr. Jesse W. Veatch, Jr., Atlanta, announces his return from military service and the opening of offices at 490 Peachtree Street, N. E., Atlanta. Practice limited to surgery.

Dr. Elkin Vogt, formerly of Atlanta, announces the opening of offices in the Henry George Building, Main Street, Lithonia, for the practice of medicine.

The Woman's Auxiliary to the American Medical Association paid an Atlantian, Mrs. Eustance Allen, the highest honor within its scope by naming her president-elect at its recent convention held in San Francisco. Others attending the San Francisco convention were: Mrs. Hewlett Askew, Mrs. B. L. Shackleford, Mrs. J. R. Childs, Mrs. Olin S. Cofer, Mrs. George Fuller, Mrs. Calhoun McDougall, Mrs. W. A. Selman, all of Atlanta, and Mrs. Claude Kelley, Lawrenceville.

The American Medical Association held its Ninety-Fifth Annual Session at San Francisco, July 2-5. Georgia physicians registered for the meeting were: Eustace A. Allen, Atlanta; C. C. Aven, Atlanta; Robert L. Bennett, Warm Springs; Lt. Charles C. Benton, Atlanta; Mercer Blanchard, Columbus; Edgar Boling, Atlanta; Allen H. Bunce, Atlanta; J. R. Childs, Atlanta; W. U. Clary, Savannah; Olin S. Cofer, Atlanta; Thos. J. Collier, Atlanta; James M. Combs, Covington; Edwin B. Davis, Jr., Byromville; Hal M. Davison, Atlanta; D. C. Elkin, Emory University; J. K. Fancher, Atlanta; James A. Fountain, Macon; George W. Fuller, Atlanta; Lt. Com. E. W. Goldstein, Dublin; Alton V. Hallum, Atlanta; Chas. E. Irwin, Warm Springs; Charles Joel, Athens; D. C. Kelley, Lawrenceville; Spencer A. Kirkland, Atlanta; Joseph C. Masee, Atlanta; Harold P. McDonald, Atlanta; James Calhoun McDougall, Atlanta; Seward E. Miller, Atlanta; B. H. Minchew, Waycross; H. W. Minor, Atlanta; J. C. Patterson, Cuthbert; James E. Paullin, Atlanta; A. M. Phillips, Macon; Albert A. Rayle, Jr., Atlanta; Charles W. Roberts, Atlanta; Frank B. Schley, Columbus; W. A. Selman, Atlanta; B. L. Shackleford, Atlanta; Edgar D. Shanks, Atlanta; Cyrus K. Sharp, Arlington; Herschel A. Smith, Americus; Jack G. Standifer, Blakely; Richard Torpin, Augusta; Perry P. Volpitto, Augusta; George A. Williams, Atlanta and Joseph Yampolsky, Atlanta.

The Fulton County Medical Society held its regular dinner meeting at the Academy of Medicine, Atlanta, August 1. Program: Case report from Georgia Baptist

Hospital, "Unusual Case of Disease of the Chest," Dr. C. C. Aven. Paper, "Carcinoma of the Cervix," Dr. J. Elliott Scarborough and Dr. Robert L. Brown.

Dr. Walter M. Bartlett, formerly of Benton Harbor, Mich., chief of medical service at Lawson General Hospital, Atlanta, and a veteran of the Army Medical Corps, has been named Assistant Chief of the General Medical Division of Branch No. 5, Veterans' Administration. In his new capacity Dr. Bartlett will supervise medical service in all veterans' hospitals in Georgia, Florida, South Carolina, Alabama, and Tennessee. He will work directly under Dr. Frank B. Brewer, director of medical service for Branch No. 5 of the Veterans Administration.

Dr. F. E. Davis, Patterson, recently released from the Medical Corps of the United States Navy, announces his association with the Ware County Hospital, Waycross, as house physician.

Dr. Oliver C. Pittman, Commerce, on return from the armed services, has re-opened an office in the Hospital Building, Commerce, for the general practice of medicine.

Dr. Edwin R. Watson, formerly of Atlanta, has returned to Macon to re-establish his practice, limited to diseases of infants and children, and will continue to be associated with Dr. C. Hall Farmer, Medical Arts Building, Macon, in the practice of pediatrics. At the time of his release from military service Dr. Watson was stationed at the U. S. Marine Hospital, Mobile, Ala.

Dr. W. D. Wilcox and Dr. Francis Ward, Fitzgerald, announce the removal of their offices to 216 South Main Street, Fitzgerald, for the practice of medicine.

The American Laryngological, Rhinological and Otolological Society has appointed Dr. Murdock Euen, 144 Ponce de Leon Ave., N. E., Atlanta, representative from Georgia on a committee compiling statistics from every state in the union regarding the incidence of poliomyelitis subsequent to tonsil or other operations. Please cooperate by completing the questionnaire if you know of such cases and return to Dr. Euen.

#### QUESTIONNAIRE

1. Patient's Name ..... Age .....
2. Address .....
3. Date of onset of poliomyelitis .....
3. Type of poliomyelitis:  
Bulbar ( ) Spinal ( ) Mild ( )
4. Was any operation performed within two months prior to onset? .....
- If so, what operation? .....
- Date of operation .....
5. What was the end-result of poliomyelitis infection?  
a. Complete recovery ( )  
b. Recovery with paralysis ( )  
c. Death ( )

#### OBITUARY

Dr. Grady Edward Clay, aged 57, Atlanta, died at his Walnut Grove farm in Walton County July 11, 1946. Dr. Clay was the only son of the late Mr. and Mrs. Augustus Caesar Clay, Walnut Grove. He attended the public schools of Walnut Grove and Monroe, and in 1910 was graduated from old Emory College at Oxford, Ga. In 1914 he graduated from the University of Michigan Medical School, Ann Arbor, Mich.

The following tribute was paid Dr. Clay by Ralph Jones in the *Atlanta Constitution* of July 14, 1946:

"Dr. Grady Edward Clay died early last Thursday morning.

"You can't tell a story about a doctor, praising him, while he is alive. Not if you would use his name. Professional ethics forbid. So, the story for this morning could not have been told while Dr. Clay lived.

"It was about two months ago. One of the best friends I have ever known called me, by telephone, at my home

one evening. When I answered the phone this friend couldn't speak intelligibly for a minute or so. I waited for the caller, whose voice I didn't recognize, to identify himself.

"At last he did so and called me by name. Then I suddenly realized, with a sense of shock, that this friend, this man I admire so much, could hardly speak because his voice was choked with tears. It is rare to hear any man cry and it is, therefore, rather shocking. And I had never heard this friend of mine display such emotion through all the years of our friendship.

"At last he regained control of his voice. Then:

"Dr. Grady Clay is dying, he said. Incurable disease and the finest doctors have agreed he cannot live more than six months longer.

"*Doctor and Patient*—Now, I did not know Dr. Clay. But I had known this friend of mine, so moved, had been a patient of Dr. Clay's for a number of years. And this friendship was the outgrowth of the relationship of a patient to a doctor he trusts.

"There are some who would, in the name of socialized medicine, make the relationship of doctor to patient an automatic, emotionless sort of thing. Real friendship between the two is oftentimes the most potent curative in the pharmacopeia.

"*Life of Service*—Since that evening call, two months ago, I have been learning facts about Dr. Clay and his career. Even in briefly itemized form it tells the story of a man who became outstanding in his profession but, more important still, gave of himself so freely that he became, to many, a living synonym for that definition of true friendship, a very present help in time of trouble.

"I did not know, until recently, Dr. Clay was the first in Atlanta to confine his practice exclusively to the eye. That he pioneered in other ways, in some forms of eye disease holding a world-wide reputation for his research and his methods of treatment.

"This is not the place to list all the honors and the achievements that came to Dr. Clay throughout his career. That was done in the news story of his death.

"However, I do want to quote from a letter he wrote, during his fatal illness, to some of the friends who had sent him messages of sympathy.

"In describing his early days of practice in Atlanta, he wrote that his collections per month, during the first six months after opening his office, were but \$12. It so continued, approximately, for a long time, he wrote.

"He was a strong believer in the medical tenet of 'no publicity.' He referred to a recent news story about a 'blue baby' operation performed in Atlanta and spoke of his gratification that the story was 'without doctors' names all over the page.'

"*The Medical Society*—I have seen many changes take place,' he wrote, 'the first being the real growth of the Fulton County Medical Society, from a small, divided society of three factions into a strong, friendly organization. I shall always feel that the development of an old apartment into the Doctors Building helped to bring together these three factions.'

"With characteristic modesty, he makes no mention of the great part he and his friendly spirit played in that removal of factionalism from the Society. Nor that he had served as President and trustee of the Society. His influence as a double-term President of the Emory University Alumni Society and on the University board of trustees was also strong.

"He was outspoken in condemnation of practices he thought detrimental to his own profession. For instance, he wrote:

"The doctors who have done more harm to the profession than all others are those who charge excessive fees. They alone are responsible for a tendency toward the development of socialized medicine.'

"He must have been a great character. A doctor of friendship so fine, his patients weep at knowledge of his impending death."

In 1915 Dr. Clay married Miss Eleanor Hall Solomon,



who died five years ago. Survivors include a daughter, Mrs. Lawson Peel Calhoun, Atlanta; a son, Grady Clay, Jr., Louisville, Ky., and three grandchildren. Funeral services were held at the Walnut Grove Methodist Church in Walton County, with Dr. Lester Rumble, Atlanta, officiating. Burial was in the churchyard, Walnut Grove.

*Dr. Arthur Preston Flowers*, aged 70, Atlanta, died July 14, 1946. He graduated from the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, Atlanta, in 1900. Dr. Flowers had practiced internal medicine in Atlanta for 40 years. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association. He is survived by his wife, a son, Arthur P. Flowers, Jr.; sister, Miss Daisy Flowers, Doraville; brothers, Dr. J. E. Flowers, Atlanta, and Mr. Lamar Flowers, Decatur. Funeral services were held at Spring Hill, with Dr. Lester Rumble officiating. Burial was in the Methodist Churchyard, Doraville.

*Dr. John T. Grace*, aged 89, retired Atlanta physician, died at his home June 22, 1946. He graduated from the University of Georgia School of Medicine, Augusta, in 1888. Dr. Grace established his residence in Atlanta in 1906 and practiced medicine until about fifteen years ago, the time of his retirement. He was a member of the Inman Park Methodist Church and of the Gate City Masonic Lodge. His only survivor is his wife, the former Miss Belle Berry. Funeral services were held from the Inman Park Methodist Church, with Rev. L. B. Jones officiating. Burial was in Oakland Cemetery, Atlanta.

*Dr. Robert Marion Gray*, aged 82, well known and beloved physician of Curryville, died June 27, 1946. Dr. Gray graduated from the University of Georgia School of Medicine, Augusta, in 1887. He was a member of the Floyd Springs Masonic Lodge, which served as an honorary escort and conducted the graveside service. Surviving are one daughter, Miss Mary Gray of Curryville; two sons, Harold Gray of Curryville, and Chief Warrant Officer Charles E. Gray, of the U. S. Army; two sisters, Mrs. Emma Eberhart, Hiram, and Mrs. Etta Norton, Rome; a brother, B. Gray, Riverdale; three grandchildren, Frances Marietta and Jimmy Gray. Funeral services were held at Johnston's Chapel, with Rev. J. B. Ward, Danielsville, Rev. T. W. Taylor and Rev. J. R. Baxter officiating. Burial was in West Union Cemetery, near Curryville.

*Dr. Simeon Edward Sanchez*, aged 68, outstanding physician, surgeon and civic leader died at his home in Barwick July 16, 1946. Dr. Sanchez was born in Trenton, Fla., and came to Barwick in 1902, after his graduation from the Atlanta College of Physicians and Surgeons, Atlanta, in 1901. He built the first hospital in Brooks County in Barwick and aided in establishing the Brooks County Hospital, Quitman. He founded the first bank at Barwick, served as mayor, and was a leader in community and farm development. Dr. Sanchez was a member of the Brooks County Medical Society, the Medical Association of Georgia, and was a fellow in the American Medical Association. Survivors include his wife, the former Miss Anna Key, Atlanta; five children, Mrs. J. R. Chandler, Rosell N. J.; Frances Sanchez, Atlanta; Mrs. E. W. Whitehead and Mrs. W. A. Maddox, Athens; and Dr. S. E. Sanchez, Jr., Barwick. Funeral services were held at the Barwick Methodist Church, following which the body was taken to Atlanta for subsequent services at Spring Hill. Burial was in West View Cemetery, Atlanta.

*Dr. William Joseph Turner*, aged 78, Ashburn, died at the Archbold Memorial Hospital, Thomasville, June 10, 1946. Dr. Turner was born in Cusseta, Ga., the son of the late Dr. O. W. Turner and Mrs. Emma Shipp

Turner. He was one of the oldest graduates of the Atlanta Medical College, now Emory University School of Medicine, graduating in 1893. He practiced medicine in Ashburn for over 50 years. During World War I he served overseas, and in World War II he served on the price panel of the Ration Board. He was a member of the Turner County Medical Society, the Medical Association of Georgia, and was a fellow in the American Medical Association. He was also a member of the Ashburn Methodist Church, the American Legion, and was a Mason. Survivors are his wife, the former Miss Julia Cawley, Cordele; one daughter, Mrs. Hazel Turner Kerns; son, Mr. O. C. Turner, Wilmore, Ky.; a grandson, Joe Turner; sister, Mrs. Homer Mims, Savannah; two brothers, J. W. Turner, Valdosta, and Milton Turner, California. Funeral services were held at the Ashburn Methodist Church, with the Rev. Shannon Holloway and Rev. O. C. Cooper, Sylvester, officiating. Burial was in Rose Hill Cemetery, Ashburn.

*Dr. George Julius Williams*, aged 32, Atlanta, died unexpectedly in Chicago July 2, 1946. Dr. Williams was a native of South Dakota, but moved to Sheffield, Iowa, during his youth. He graduated from the Northwestern University Medical School, Chicago, in 1941. He entered the Army Medical Corps in 1942, served in France for one and a half years, and was discharged last September, with the rank of captain. He was studying at the Cook County Graduate School of Medicine, Chicago, at the time of his death. Survivors include his wife, the former Mary Joyce Papy, Atlanta, a son, William E. Barnum; his parents, Mr. and Mrs. J. L. Williams, Sheffield, Iowa; sisters, Miss Cecile Williams, Sheffield, Iowa; Miss Frances Williams, St. Cloud, Minn.; Mrs. Howard Bach and Miss Avis Williams, both of Sioux City, Iowa; and a brother, Gilbert Williams, Rockford, Ill. Funeral services were held at Spring Hill, with Dr. William V. Gardner officiating. Burial was in West View Cemetery, Atlanta.

#### ARMY PHYSICIAN FINDS PENICILLIN EFFECTIVE FOR SORE THROAT

After studying 28 soldier-patients in the Hawaiian Islands, Capt. Selvan Davison, Medical Corps, Army of the United States, concludes that penicillin has a definite place in the treatment of acute sore throat.

Writing in the July 27 issue of *The Journal of the American Medical Association*, Captain Davison says that while penicillin gave good results in all of the acute sore throat cases which he treated, it was found especially effective in patients whose illness was due to the germ called hemolytic streptococcus. This germ is implicated in a large number of acute sore throat cases.

Captain Davison states that he undertook his study because doctors forever are seeking an ideal therapeutic measure which will obtain rapid and complete cure for sore throat.

The army physician quotes one investigator who previously had treated 28 cases of acute sore throat with penicillin, using 15,000 units every four hours, day and night. In this study, it was found that cases treated for less than six days with 15,000 unit dosages of penicillin showed comparatively poor results because of frequent relapses; yet patients treated for six full days showed excellent results.

Captain Davison says that on the basis of the previous investigation, he studied the possibility of giving a shorter but more intensive course of penicillin treatment.

All of Captain Davison's patients were young adults with no complicating diseases. No patients were treated who had been ill for more than 48 hours.

Penicillin was administered in the amount of 20,000 units every three hours, day and night, by intramuscular injection. The average total dosage of penicillin was 360,000 units over a period of 54 hours.

There was only one relapse, in which recovery occurred without further penicillin. One case did not respond until sulfadiazine replaced penicillin as the treatment.

Most of the patients showed complete recovery in two or three days. The patients from whom no bacteria were obtained displayed normal throats in an average of under four days.

"It must be remembered," Captain Davison writes, "that the periods of time noted are the upper limits. Disappearance of symptoms and of signs means complete absence. There had to be not the slightest pain on swallowing nor any remaining exudate or inflammation before a time element was established."

#### HABIT-FORMING PROPERTIES OF PAIN RELIEVING DRUG EMPHASIZED

Emphasizing the fact that Demerol, a substitute drug for morphine, has habit-forming properties, H. J. Anslinger, Commissioner of Narcotics, Washington, D. C., writing in the July 13 issue of *The Journal of the American Medical Association*, says:

"Now comes an article by Paul de Kruif in the June issue of the Reader's Digest entitled 'God's Own Medicine—1946' under the headline 'The pain-fighting power of demerol is as miraculous as that of morphine—without the opiate's danger of addiction.' This article adroitly makes no reference to the work of Dr. C. K. Himmelsbach of the United States Public Health Service and Drs. Hans H. Hecht, Paul H. Noth and F. F. Yonkman of Detroit, all of whom warned of the danger of addiction.

"Demerol was placed under federal narcotic control by the Congress because of evidence given before that body of its dangerous properties. Some of the persons referred to in de Kruif's article could have attended the hearings before the Ways and Means Committee and could have testified as to what they thought about the drug, but they elected to remain silent.

"I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by de Kruif that the drug is free from addiction properties. This is information somewhat similar to that which appears in the circular distributed by the manufacturer of Demerol to push sales. Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol."

Demerol, also known as Dolantin, was discovered in Germany and made its appearance several years ago in the Argentine. The author points out that both of these countries immediately placed the drug under strict control.

#### SMALLPOX INCIDENCE DECLINES

Smallpox reached its lowest ebb in the United States in 1945, according to statisticians of the Metropolitan Life Insurance Company. Last year only 346 cases were reported in the entire country, and 13 states and the District of Columbia were completely free of the disease. In Canada only five cases were reported, the statisticians say.

The steady decline of the disease is strikingly brought out by the statisticians by contrasting 1945's 346 cases with the 48,920 cases reported in the United States as recently as 1930.

The smallpox-free States last year, all located on the Atlantic seaboard were Connecticut, Delaware, Florida, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, West Virginia, and the District of Columbia. Top honors went to Rhode Island, which has not had a case since 1928. The poorest records were made by Indiana, with 50 cases; Arkansas, 31; and Mississippi, 25.

"As long as reservoirs of infection are permitted to remain," say the statisticians, "they will continue to be potential foci of smallpox epidemics, not only for the local residents but, because of modern transportation facilities, for the people of other States as well."

#### SONGS FOR AILING VETERANS

Ex-Lieutenant Martin Joel Betnun, 28, former University of Chicago student, who, during the war, led hundreds of thousands of GIs in morale-lifting community singing, is going to spend the next few months doing the same thing, only this time as a civilian in Veterans Administration hospitals and homes.

Mr. Betnun, traveling in an Army jeep, will tour 106 VA hospitals and homes throughout the nation, making a brief stop at each to lead disabled veterans in community songs, either in wards or in hospital auditoriums.

The songs will be a mixture of old and new, most of them hostuligally familiar to every man who served his country in time of war.

The songs are included in booklets entitled, "The Sad Sack Sings," which Mr. Betnun will distribute to each patient. The booklets are illustrated with the war-famous Sad Sack cartoons by ex-Sgt. George Baker.

Mr. Betnun, a native of Salt Lake City, Utah, will resume his studies at the University of Southern California upon completion of his swing about the country. He is specializing in social welfare administration work, with special attention to entertainment and recreation.

**SOUTHERN MEDICAL ASSOCIATION** annual meeting, Miami, Fla., Nov. 4-7, 1946. Hotels: McAllister, Columbus, Colonial, Everglades and Alcazar. Make reservations direct with hotel of your choice.

**WANTED PHYSICIANS**—There are many vacancies with the Veterans' Administration for full time, part time and fee basis physicians over the state. Any one interested, please communicate with the Manager, Veterans' Administration, 5998 Peachtree Road, Atlanta.

**POSITION WANTED:** Young physician, eligible for discharge from military service July 1st, desires position with older physician doing general practice and surgery in small town. Write 95 Engineer Drive, Benning Hills, Columbus, Ga.

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### PSYCHOSOMATIC GYNECOLOGY

JEAN PAUL PRATT, M.D.

*Detroit, Mich.*

Psychosomatic gynecology may sound formidable but it is merely a new term to invite attention to something that is very old. During the war the term psychosomatic has crept into medical parlance a great deal. Many doctors, having received excellent training and experience in this field, are now returning from service to their practices with new enthusiasm for this branch of medicine.

What is psychosomatic gynecology? Sometimes gynecology refers chiefly to surgery of the female pelvic organs. Sometimes it also includes the treatment of disease of the pelvic organs and all mental and emotional problems are excluded; i.e., mind or body. It is known now that every emotional change has a physical counterpart. It becomes obligatory, therefore, to consider mind and body. The specialist can no longer ignore this relationship, nor can he refer all emotional problems to a psychiatrist. In the first place, many patients would not go to a psychiatrist. Secondly, there are not enough psychiatrists to care for all such problems, for it is variously estimated that 35 to 75 per cent of patients in hospitals are there for mental or emotional problems. Thirdly, many of the physical and emotional problems are so closely

related that they cannot be dissociated. The relation of mind and body is important in all fields of medicine, but is especially important in gynecology.

Why have mind and body been dissociated? The discovery of cellular pathology a hundred years ago introduced a new phase in diagnosis and treatment. Previous to that time there was much speculation regarding disease with emphasis on the mental and emotional reaching an acme with Mesmerism 150 years ago. Cellular pathology in 1850 emphasized the physical basis of disease. Then, bacteriology, chemistry, biochemistry, and endocrinology focused attention more and more on the body, thus developing the machine age of medicine. Only in recent years has it been appreciated that physical change affects the emotions and that every emotional change affects the physical. Today, therefore, complete study of disease includes the mind and the body; i.e., psychosomatic medicine.

Many times one is told that mental illness is due to gynecologic disorders, but a careful survey of gynecologic diseases in the hospitals for mental diseases shows that there is no greater incidence of gynecologic trouble in those places than in the average run of human individuals. One cannot say, therefore, that mental illness is necessarily associated with gynecologic trouble. Now we have psychiatry and psychology coming to the field of gynecology. This was brought to my attention a number of years ago by the fact that among three patients who had the same condition and who received the same operation, one completely recovered,

Invited guest speaker at the public meeting of the Medical Association of Georgia, Macon, May 8, 1946.

From the Department of Obstetrics and Gynecology, Henry Ford Hospital, Detroit, Mich. -

another improved, while the third showed no improvement.

To illustrate the futility of considering only the physical relation, may I cite one case that nearly became serious. This individual was a woman of 50 odd years who had a cystocele and came to the hospital primarily for hyperthyroidism. While there it was decided that she should have the cystocele repaired. It was repaired with very satisfactory results. During her stay in the hospital she was happy about her condition and remained so for two weeks after leaving. We heard nothing from her for quite some time. The next thing I knew she had returned to someone else in the hospital and was very angry with me and wanted to sue me and the hospital for recurrence of her trouble. Examination at that time showed the mechanical results of the operation to be satisfactory. Her mental state had become a serious problem. A psychiatrist was called. Briefly, he found that this woman was the mother of two children both of whom died very early in life. As compensation for the loss, she had mothered a woman with whom she was intimate in the church and lodge. Two weeks after she had left the hospital following the operation, her intimate associate had died. The death was such a blow to her that she could not compensate for it and looked for the nearest big event in her life to blame for her condition. The recent operation being nearest to it received the blame, and it took the utmost skill of the psychiatrist to straighten out the problem for that woman. The above case illustrates why I mention that with the same mechanical procedure performed on similar conditions, the end result may vary greatly.

In approaching the application of the emotional treatment and psychosomatic aspect of gynecology, what can we do in regard to operation? A great deal, particu-

larly in the preoperative stage. It may be easy to see the mechanics. A patient needs an operation, and it is easy to determine what procedure is desirable. Now one should consider what emotions are commonly involved. Fear is most common. Fifty per cent of the patients who leave their rooms to go to the operating room have the feeling, "I probably won't come back." Ninety-nine and some tenths per cent do come back. That expresses the most common fear. This fear of not returning can be prevented if the operator, resident, or some other capable person, explains to the patient that operation is not a thing to be feared. Sometimes the fears are complicated, and more than casual observation is required. For instance, a hyperkinetic patient was admitted to the hospital for a simple operation. The nurse called saying that the patient was very obstreperous, refused to take her sleeping medicine, and got out of bed. When I dropped in to see the patient, she said to me, "Doctor, I am so glad you came. I just could not go to the operating room until I had told about an abortion done years ago. I have never told a soul. I simply could not think of taking the risk of an anesthetic and going through the operation until I had that off my mind." As soon as she told her secret she relaxed and had a good night's sleep. Had she not been given an opportunity to relieve her mind, the patient might have been very troublesome.

Among the common fears and anxieties related to gynecological operations are fear of death, fear of being maimed, fear of loss of sex, and fear of becoming masculine or prematurely senile. In a few moments of apparently casual conversation these subjects can be covered, preferably by the one who is to operate. Assistants and residents should learn the technic. One may say that death from operation is far



less likely than from automobile accident. The site of the incision and the usual appearance of the scar may be explained. A statement that sex habits already established are not lost even by a complete operation is reassuring. Approaching neutrality with advancing years is not to be confused with tendency to masculinity.

Closely akin to the fears of operations are the fears of anesthetics. Here, too, fear of death is foremost. The possibility of choking or swallowing the tongue has caused many a nightmare. No less important is the possibility of divulging secrets when being anesthetized.

A little time spent before operation in discussing the ordinary fears may give comfort to the patient, prevent postoperative discomfort, and save time in the end for the surgeon.

Another situation demanding thoughtful consideration is the management of terminal conditions, especially hopeless cancer. Ministration for the physical comfort is assumed. For mental peace, maintaining hope to the end is essential. I believe that one should avoid, if possible, telling a patient that she has cancer. Occasionally this allows the woman to infer unjustly that her trouble is due to radiation or surgery. If the family be correctly informed, the unjustified inference by the patient matters little and permits her to maintain her hope of final cure.

In the practice of gynecology fear of operation, of anesthetic, and of cancer are most frequently encountered; however, by careful interviews, several other phobias may be elicited. Among these may be mentioned fear of incapacity, insecurity, unhappiness, etc., but probably the next most common phobia is fear of pain. A specific example of this is dysmenorrhea. Dysmenorrhea is treated in a variety of ways, none of which is entirely satisfactory. Some

would explain all dysmenorrhea on an organic basis, but frequently no organic cause can be found. Others stress the importance of the emotions as a cause. Sometimes both causes can be demonstrated. It is assumed that in every instance the organic cause will be sought. After that the emotional factors should be explored. At this point it is important to assure the patient that it is understood that the pain is real and not imaginary. Furthermore, the emotional disturbances are not of the present but antedate the onset of dysmenorrhea. May I cite one or two instances to illustrate this relationship.

Here is a woman about 33 years old when first seen some 20 years ago. Her dysmenorrhea developed about the age of 18 and increased in severity until her brother, a well known physician, was giving her morphine at each menstruation to relieve her pain. On her brother's recommendation she had seen 20 different physicians and had 3 operations (uterine suspension and 2 dilatations with curettage). Little or no relief had been experienced. Having had all these varied treatments, she came for one more examination with the attitude, "Well, there isn't anything else to do—I will try once more, then I am through." After careful examination no organic trouble was found. She was so informed, but also was given an explanation of the relation of emotional disturbances to pain. Some of her emotional problems were discussed. Being an intelligent woman, she accepted this information without too much skepticism. On leaving the office she promised not to take any more medicine until she returned. Three months passed before I heard from her. Then she called to say that she had taken no medicine and had menstruated three times without pain. She requested an early appointment. At this visit she divulged more of her emotional problems,

stressing her fear of being in a closed room, riding in an elevator and being in crowds; i.e., claustrophobia. Entering the hospital for a few days gave her time for reflection whereupon she revealed her innermost emotional conflicts which were pronounced during adolescence. Her mother was a very excellent and kind-hearted woman who was thoroughly respected by the family. The keynote of her training was "do not". Special emphasis was laid on the dangers of masturbation until the daughter was frightened, for she now admitted that she had been a victim and believed she was ruined thereby. As a result she had avoided all male companions. Claustrophobia had gradually developed. Briefly, the release from conflict and development of understanding enabled her to live a normal life. Later she took a trip to Europe, rode in elevators without qualm and mingled fearlessly in crowds. Dysmenorrhea never recurred and she passed through the menopause uneventfully.

Another instance of dysmenorrhea in a woman of 26 may be briefly cited. About the time she began to menstruate the family were at a summer cottage. Being crowded, the girl slept on a cot in the maid's room. During the night someone came into the room and got in the maid's bed. The maid, suspecting that the girl had heard the commotion, said, "If you dare to repeat what you heard last night, I'll cut your throat." The girl confessed her sin to the priest, but this did not relieve the tension and anxiety arising from the incident. The true facts were repressed until her interview at 26. In the meantime she developed an increasing dysmenorrhea which had never been relieved by medication. Unloading her emotional conflicts and developing understanding completely relieved the dysmenorrhea.

Amenorrhea may result from fear or

tipped over in a boat and nearly drowned. Menstruation ceased for one year. When another menstruation occurred, a similar fright; e.g., a girl about to menstruate was accident happened. She never menstruated after that.

Pseudocyesis, which represents another emotional conflict, is too familiar to all to require further elucidation. With or without amenorrhea a woman may be convinced that she is pregnant from 2 months to 2 years and manifest all the symptoms of pregnancy. Patience and understanding are required to persuade these unfortunate individuals that they are not pregnant.

Masturbation presents an exceedingly difficult psychological problem. Howard Kelly once said, "Masturbation is the hardest subject to lead up to but it is ten times harder to get down from." That may be right. It is a very intimate subject, something which a woman will not discuss with a friend. They will often discuss sex life with a great deal of freedom, but if masturbation is mentioned, they shy away. Let me cite briefly one or two instances.

A sister-in-law of a physician appeared at the hospital from time to time for examination. Her hospital record was growing and growing without evidence of any great change in the patient. Each time she came for examination she was referred for a gynecologic check because at one time someone had suspended her uterus hoping to relieve some of the symptoms of which she had complained. None of the gynecologic examinations revealed any organic disease. She was an intelligent woman. I wondered about her emotional state; at one of the examinations I took occasion to discuss emotional problems of women in general, mentioning during the discussion the subject of masturbation without being too specific. Six months later she came for another general check-up. When she came to the



Gynecological Department, she burst into my office and said, "Doctor, the last time I was here you said something that interested me very much." She immediately began to tell about her life at the age of 16 or 17 when her mother told her that if she ever dared to masturbate she would never be fit for marriage and her life would be ruined. The admonition sank deeply. The girl had been interested in three different young men but because of her belief in her mother's advice, she put them off when the question of marriage was broached. We discussed her problem fully and frankly. That was her last official visit to the hospital. She married one of the men whom she had formerly refused and has changed from a chronic invalid to a sound, healthy woman.

Another illustrative case was a young woman complaining of dysmenorrhea and headache. She was introspective, discouraged and disheartened. She felt that she was unattractive and could not face the world. Her personal appearance reflected neglect and carelessness. Her posture was poor. Physical examination revealed no abnormality. Her environment was discouraging for she was the work-horse and too busy to look after herself. An attempt was made to show her the potentialities being overlooked. One could honestly tell her that she could be good looking if she took the trouble to improve her posture and give thoughtful attention to her dress. The second visit showed a great transformation. Her posture was erect and her new dress and hair-do were becoming. Most important of all, she had learned that she was attractive to men. Her headache and dysmenorrhea had gone, yet she had not been given a drop of medicine.

The dominating mother presents another problem. I do not refer to childhood and adolescence but to middle life. A husband came to complain that his wife was cross,

irritable, tired all the time and hard to live with. This proved to be coincident with her mother having come to live with them. The mother, a meddlesome, elderly lady, was constantly interfering. There was constant friction. Each member of the family was found to be in good health, but the elderly mother was childish and lacked interests. Suitable hobbies and amusements were found to occupy her mind and time. Peace and harmony returned to the family.

May I mention here my sympathy for the pretty girl, the girl with doll-like beauty? She seems to be riding on the crest of the wave and everything is wonderful. She is pursued by flocks of suitors without any effort on her part. Then as the years go by, that beauty fades. Her attractiveness wanes and too often these unfortunate individuals become truly miserable. The earlier she learns something worthwhile to replace her physical beauty, the happier she will be.

Much could be said about the emotional conflicts associated with the menopause, but let us consider here just one symptom languor or fatigue. Undoubtedly the most common cause for this symptom is boredom. Having been a very busy woman for years, rearing her children and managing the household, she suddenly realizes that she no longer has these cares and responsibilities. She had been too occupied to read or pursue any hobbies, so now with so much free time she is bored. If she is found physically sound, the solution of her problem is to encourage her to develop suitable hobbies or interests and the languor will disappear.

Mention may be made of a condition, the prevalence of which is not generally recognized, viz: perversion, particularly homosexuality. The subject is presented not for discussion but merely to warn that youth should be given the facts in order that they may recognize "the pairs," "the queers," etc. The number of teachers and students

involved in colleges and universities is alarming. It is our duty to become informed to protect youth. They should be taught to recognize and avoid.

A few of the many emotional problems have been briefly presented. What are we going to do about them? First of all the doctor should investigate and evaluate his own personality. Fundamental to handling emotional problems is the relation of doctor and patient. One can generalize only to a limited degree. Dr. A may impress a patient one way and Dr. B another. Dr. A cannot say, "I asked these questions and made these suggestions, now Dr. B you do likewise." Each doctor must be able to adjust to the specific problem whether it be a frivolous youth, a querulous spinster, or a dominating woman. Establishing confidence and showing a sympathetic understanding are the keys to success. One cannot say, "You tell me everything and I will not tell a thing." A proper relationship has not been established if a patient says, "You won't tell that, will you?" Sincerity of purpose, honesty, sympathy—the art and soul of medicine—are all essential to lay the foundation of success in this field. It is remarkable how often merely telling troubles and experiences in confidence helps to crystallize the ideas of the teller without a single suggestion from the doctor. Being alert, the doctor may be able to add some helpful suggestions to enable the patient to see the problem as a whole.

Indecision is frequently the basis of serious conflicts. Rarely should we decide for the patient, but we can help or push them to make a decision. A useful formula has been: "You cannot go East and West at the same time and you cannot stand still. You must choose East or West. Whichever way you go, you will have to give up something you would have gained if you had gone the other direction." Let them enumerate these

advantages and disadvantages of going each way, then push them to their own decision.

The level of intelligence influences the procedure used and determines more or less the success in relieving emotional turmoil, ( $0 - 0 = 0$ ). If the intelligence is low, constant supervision by some relative or interested person is necessary to help such an individual in a simple environment. With a high level of intelligence, the emotional disturbance may be greater but such an individual also has greater ability to manage his own problems.

So far a few illustrative problems have been presented and a few means of solving them have been suggested. May I now invite your attention to prevention which must begin at an early age? One of the greatest difficulties in obtaining a frank discussion of body function, including sex and reproduction, is lack of a suitable vocabulary. Children become curious about words written on alley fences and similar places. They are aware that those words should not be used in polite society, therefore do not know how to ask their parents the proper questions. Mothers are sometimes guilty of stigmatizing normal function by suggestive words; e.g., speaking of menstruation as "the curse." Many problems may be solved by seating parent and child together in the office and teaching them a few important terms and their definition, then sending them home for their own frank discussion.

The following experiences will emphasize the fact that there is need for sex education. For several years it has been my pleasure to meet groups of high school girls for health talks. At first the teachers announced a sex talk, but that is misleading and places an unfavorable emphasis. We insist that the subject be a health talk. The students are permitted to write anonymous questions and are promised an honest answer. At the beginning of the talk they are reminded that



the remarks will be confined to answering the questions in hand. Since some of the subjects are very frank, anyone not choosing to hear the answers is requested to leave. None ever do. They are requested to go to their mothers after the talk, tell them about it, and ask for further enlightenment. In order that you may know what girls of 16 and 17 are thinking, a few of the questions they have asked are presented here:

1. "What do you consider necking?"
2. "Is it wrong to neck?"
3. "Are French kisses dangerous?"
4. "Why do boys think you are more grown up if you want to neck?"
5. "How old do you think a girl should be to marry?"
6. "If a girl goes horseback riding and there is a bloody discharge later, does it necessarily mean the main head is broken?"
7. "Is it bad for a young girl's health to have a baby?"
8. "How old is a girl before she is fully matured?"
9. "How does drinking intoxicants affect the sex organs?"
10. "What causes a premature baby?"
11. "When a child of 8 or 9 is raped, some say the bones are crushed. Is this true?"
12. "Can a person knowing nothing about delivering a baby deliver one in a pinch?"
13. "How messy is it after a baby is delivered?"
14. "What about that 8 or 9 year old Indian girl who had a baby?"
15. "What happens to the baby in the late stages of pregnancy when an accident occurs which prevents the baby from developing any more?"
16. "What does a doctor do to deliver a baby?"
17. "How soon after childbirth does the mother begin menstruation again, and does

it last a whole month?"

18. "Please explain about birth control."
  19. "What connection do dreams have with sex?"
  20. "Is there just a certain time of the month that a girl can become pregnant? If so, when?"
  21. "What would happen if a girl had sexual intercourse before she began to menstruate?"
  22. "How old are boys before they can make a girl pregnant?"
  23. "Is a boy more emotional than a girl?"
  24. "Is there such a thing as a man having a tendency towards women's traits, or vice versa?"
  25. "What are the circumstances when there is an affair between 2 men or 2 women, or is this idea just plain batty?"
  26. "Is an older person who has never married or had sexual intercourse as normal in every way as married people?"
  27. "Is it true that married people live longer than spinsters and bachelors?"
  28. "Is there pain when a girl has her first intercourse?"
  29. "If tough physical exercises are supposed to kill the desire for mating (boys), why is it that that doesn't necessarily pertain to the boys in the armed forces and overseas?"
  30. "Is a man's desire for mating so great that he doesn't care what race, color, or creed the woman is?"
  31. "Is the matter of sexual intercourse instinctive?"
- You might say these must have been girls who came from families of low intelligence. No. They are girls from the average class of high school students, even better than average because they had interest enough to find out something besides what is in books. They are girls who want to know but probably have not found honest answers at

home. What is the reason? It is usually a question of vocabulary. It might require reading on the part of parents. Call things by their proper name so there will be no mistaking of the terms used. Year after year we attempt to answer similar questions, and it is very interesting to go back over them because one can predict the age of the questioner by the type of questions asked. I present this as a means of something we can do in the way of prevention.

As mentioned before, psychosomatic medicine is not a new problem. Some emotional problems have been summarily presented. Psychosomatic medicine is the science of the art and soul of medicine.

#### "SUGGESTED SCHOOL HEALTH POLICIES"

Fewer accidents in athletic programs, less severe epidemics of contagious diseases spread through school contacts, and improved programs of health education are likely in the coming year, Dr. Charles C. Wilson of Teachers College, Columbia University, chairman of the National Committee on School Health Policies, predicted in announcing the fifth printing of "Suggested School Health Policies," of which 50,000 copies have been distributed. This charter for school health, the work of a committee representing 15 leading health and educational organizations, was published last December and has achieved national recognition as an authoritative guide to school health programs.

"The National Committee has evidence," Dr. Wilson said, "that many school administrators and teachers have accepted this book as a basis for discussion of health matters and for revising their own school health practices. In line with the charter's recommendations, in the coming school year we may look forward to the organization of more numerous and increasingly effective school health councils. More and better trained medical advisers will be appointed. We may expect fewer accidents and mishaps in athletic programs and less severe epidemics of contagious diseases spread through school contacts. Health education programs will be evaluated and expanded. Schools and communities alike will feel the impetus to better health supplied through the consensus of informed opinion which the bulletin provides."

"Suggested School Health Policies" is a 48-page booklet published by the Health Education Council, 10 Downing Street, New York 14, N. Y., and is designed to serve as a guide to show how schools and communities can devise balanced programs of health education and health care. Many of its suggestions cannot be adopted overnight, its authors agree, but pursuit of such improved practices will inevitably result in higher standards. Individual schools are at liberty to adopt or modify the policies in line with their own resources.

## PSYCHOSOMATIC ASPECTS OF PROBLEM CASES IN MEDICINE AND SURGERY

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Psychosomatic medicine is defined as the study of illness in terms of physiologic and psychologic processes, but the term means more than that. It seems to me that it is best defined as a term used by a group of workers interested in conditions where structural, anatomical, and physiological components are intimately fused with personality determined emotional factors.

From the structural or anatomical point of view, structural and anatomical conditions might be placed at one extreme and personality ones at the other. For example, a broken bone or skin abrasion is at one end and character disorders are at the other. Where conditions spoken of as structural and personality determined meet, there is a province of psychosomatic medicine, principles of which are the same as those which apply to problem cases in psychosomatic surgery.

Psychosomatic medicine is also defined as the study of illness—and illness is often the result of a trauma, of course—in terms of the interrelationship of the physiologic and psychologic processes.

Going back to the time of the Christian Fathers, the care of sickness or of injury consisted of a judicious mixture of psychic and somatic intervention. To the nineteenth century, the era of materialism and specialization, belongs the responsibility for separating the two and neatly docketing each in a separate file.<sup>1</sup>

Man enters the world with certain tissue potentials of inherited traits. This basic material cannot be exchanged for a later model but even inherited traits may be modified by time and circumstances. The



change in eye coloration, hair color and body configurations are examples. Within the limits of these basic potentials every individual has a wide range of possible behavior, and the course of his life stream will depend on the interaction of his drives and the demands of his environment. Someone has said that "All men are by nature equal, but they differ greatly in sequel".

Anxiety, either unobjectified or accompanying a fear of operation pain, illness or death, is the most common symptom in any sick patient. Physiologists have demonstrated the alterations in physiology produced by anger, fear, and other emotional states in both man and animal, changes principally inaugurated via the autonomic pathway and abetted by the endocrine system. These changes may, and often do, produce subjective sensations which one person may note and another ignore. In either case the change in function and the sensation produced are normal components of anxiety. The normality of these body reactions to emotional stimuli should be observed and carefully considered. In many instances all of the symptoms are due to the patient's increased attention to awareness of normal body functions. The symptoms may persist or intensify if a chronic psychologic stimulus produces a continued state of auto-hormonal imbalance.

In the anticipation of an operation, or even an examination of trauma or its treatment, a patient presumably has fear and dread, possibly more in case of the former. An operation often produces such an impression on a patient's memory that he may for the remainder of his life refer to past events as happenings before or after my operation. The matter of the surgeon obtaining a conviction of confidence in himself on the part of the patient is of much more importance than has been credited to it. There is a close personal relationship

between the surgeon and his patient.

Today the surgeon does not ridicule psychoneurotics as he was wont to do some years ago. Today the surgeon leans on psychiatry, even though there is such a wide divergence in the views of psychiatrists.

The surgical wards offer daily instances of various degrees of anxiety by patients with trauma, or facing operations, or both. Before operations there would be the patient whose symptoms of disease were in reality a psychoneurosis, and the patient with anxiety associated with an organic surgical disease or its treatment or the treatment of trauma.

A study of conditions before and after operation by methods known only to the experienced psychologist would advance a knowledge of both psychiatry and surgery. The surgeon seeks to obtain as thorough an understanding as possible of what sort of a person his patient is—what his growth in his environment was like, how he "experiences".<sup>3</sup>

In view of the history of psychosomatic medicine, which really goes back to Hippocrates and the Pythagorean era, since the interrelationship was then recognized, it is somewhat surprising to consider a statement in the first issue of "Psychosomatic Medicine," January, 1939, which carries the idea that a new and startling discovery had been made: "Psychic and somatic phenomena take place in the same biological system and are probably two aspects of the same process."

Nevertheless, some such statement, it appears, was necessary, for the trend toward specialization in psychology, and medicine had progressed until there was little meeting of minds between the exponents of the two fields. For some years the practitioner of medicine had felt impelled to make a choice; he might join the ranks of pathologists and seek the explanation for and treat-

ment of all lesions in the light of tissue changes, or he might enter the vague and mystic world of psychologic healers, and place his faith in the concept of mind over matter.<sup>4</sup>

Dunbar says: "We know now that bodily changes may be brought about by mental stimuli, by emotion just as effectively as by a bacteria, toxins, and the physiological changes accompanying emotion may disturb the function of any organ of the body."

Bergman tells us that "We can no longer separate either nervous nor organic, or either functional or organic." Grinker has noted that in anxiety which is prolonged, psychologic flight takes the direction of regressive and infantile modes of emotional expression. He states that "these result in visceral expression of organic dysfunctions, which we term organ neuroses, that constitute the first step toward organic disease." Mohr concludes that there is no such thing as purely psychic illness or a purely physical one—but only a living event taking place in a living organism.<sup>5</sup>

At the meeting of the American Society for Research in Psychosomatic Problems in Detroit, May 9, 1943, Colonel Leonard Rowntree, Chief of the Medical Division, Bureau of Selective Service of the War Manpower Commission, related that Selective Service is interested in psychosomatic disorders because of the problems of selection for the armed forces, and spoke of the clinical opportunities afforded by war "on a vast and heretofore unheard of scale." The title of Col. Rowntree's address was: "The Unfit: How to Exclude Them." This, of course, shows the application of psychosomatic principles in war.<sup>6</sup>

There is always the difference of opinion as to whether a patient with an incurable affliction should be told the truth or a falsehood; and if he is told the truth, shall it be done by gradually working up to the bad news, or should he have the worst news first

and subsequently be given every encouragement which it is reasonably possible to give. Then, too, there are the two patients who are to have the same operation or wound treatment the same morning—one dreads "going to sleep" and the other cannot bear the idea of being conscious "under the knife."

In a hospital in Nashville, Tennessee, all ward patients were subjected to psychiatric investigation. Almost all of the ward patients of surgery had been in a year exposed to a psychiatrist, and 64 patients had a complete psychologic study except for psychoanalysis. Only two patients were not agreeably cooperative. During the same year in the private pavillion there had been universal objection, and in most cases positive refusal to accept a specific request for psychiatric consultation. The explanation for this difference lies in the fact that psychiatrists were not labeled in the wards—they were not only permitted but encouraged to pose as members of the surgical staff.

The frequency of the occurrence of the modification of behavior because of anxiety from other sources than surgical organic diseases and their surgical treatments is illustrated by the results of the psychiatric examination of 14 consecutive cases of acute appendicitis operated upon and found to have a definite acute inflammatory process in the appendix. Seven of these patients were found to have evidences of anxiety of sufficient gravity to be of clinical significance. In two cases operated upon during the same period in whom no organic change was found in the appendix, psychiatric examination disclosed sufficient evidence to justify the conclusion that the symptoms and signs of acute appendicitis which were such that an operation was indicated, were in reality manifestations of neuroses.

The patient with symptoms and signs of



acute appendicitis sufficiently characterized to make delay of operation dangerous, and subsequently at operation found to have no demonstrable pathologic change, constitutes a problem which surgeons have not devoted the attention the problem deserves. The importance of considering psychic aspects of malignant tumors, disabling deformity or unsightly disfigurement is such that pre-operative preparation of the patient for these results is just as important as is the transfusion of blood or compensation for vitamin deficiency to reduce the risk of operation and promote the healing process in the operation wound.

Frequently patients manifest evidence of a sense of relief from anxiety because wounds are to be treated by a method which may appeal to them. This suggests that the psychoneurotic patient who makes much of his or her previous operation has not in reality been made a psychoneurotic because of this operation, but that he or she is merely utilizing this experience as an integral part of her neurotic pattern. It is also not impossible that the patient who states she has been in absolutely perfect health since a cholecystectomy, with the removal of a perfectly normal gallbladder, is contemplating the operation from the crest of a wave of mild-manic depressive insanity.

Recently a patient upon whom had been performed a radical removal of the rectum made a trip from a distant city in order that she might let her surgeon know from her own lips what a wonderful asset she had in her perfect colostomy.<sup>7</sup>

There are many relatively mild cases of cycloidism, many persons who shift from phases of happiness to those of depression. When the stages are severe, leading to a diagnosis of manic-depressive psychosis, the illness should be treated by a psychiatrist.

But the milder cases of cycloidism are usually first seen by another physician and,

as in schizoidism, the patient presents the organic manifestations of his troubles. And again no organic cause is discernible. Seldom does the subject appear before the doctor while in the upswing stage, because then he is confident and sure of himself, and physically he feels perfectly fit.

Treatment of the individual in the depressive state in traumatic surgery or organic disease is both somatic and psychic, with greater emphasis on the latter. All available measures for good physical hygiene should be instituted in order to combat the deleterious influences that the emotions are playing upon the body. The physical measures necessary to maintain some semblance of health are well known to the physician.

Psychotherapy should be promptly instituted. In the beginning persuasion and assurance are highly desirable, for the patient needs to be considerably supported mentally. He is like a lame person—hurt by walking—afraid to take the next step. He should not be encouraged to take a rest, first because rest only gives him more time to bemoan his lot in life or the possibilities of his injury, or wound, or illness; and second, because some constructive activity, however meager, buttresses his morale.

The patient needs someone to lean on, someone to whom he can relate his troubles, someone to whom he can transfer his feelings. If the depression is mild, the assurance type of therapy does not have to be kept up long. The physician may begin to use the more fundamental treatment; namely, that which is designed to remove the cause of depression. The purpose of deep psychotherapy is to make an extensive inventory of the patient's life, past and present. This provides the patient with some emotional outlet.

By this means emotions are drawn away from the body; as they are being drawn away from the body they should be re-directed upon natural and environmental interests. The best technic on the part of the practitioner is to be a good listener and judicious adviser. The physician may well be like a pilot who turns the controls to the trainee. To do this properly takes much training and experience, for in all treatment procedures the physician is conditioned to take over full control and the patient is accustomed to follow. The traditional patient-physician relationship is reversed in this.

Gradually the patient will see what he previously had not seen; he had not seen it because he did not want to see it, and he did not know how to see himself as others saw him. He will steadily find out how blindly he has been going through life, how blind he was to his faulty ways, how, without knowing it, he was driving ahead without regard to warning signals.<sup>8</sup>

Neuroses rarely occur in severe injuries. They are brought on by overwork, worry, grief, insomnia, alcoholism, exhaustion, moral, mental, social and physical excesses. No physical injury to any part of the body is too great nor yet too slight to induce symptoms in those ripe for it. The element of suggestion is very important. There is no form of injury more capable than another of inducing traumatic neuresthenia, and thus head, spinal and pelvic injuries are more competent in producing causes than injuries elsewhere inflicted.

H. W. Smith and S. Cobb have produced a work, "Relation of Emotion to Injury and Disease." This was published in 1943 and covers problems in mind and body coordination and poor explanation at the beginning of treatment.

E. Weiss and O. S. English have a publication of special topics in connection with

psychosomatic medicine. This takes in allergy, arthritis and other subjects. It is found in *Psychosomatic Medicine*, published in 1943 in Philadelphia. Dr. Weiss is one of the authorities on the subject. He had Dr. English, in *Military Medicine*, take points with regard to mind and body coordination and the importance of adequate treatment in the beginning and of frequent visits to patients.

Dr. George H. Stevenson had an article on "Psychosomatic Medicine and the General Practitioner" in *Diplomat*, published in 1944. In the proceedings of the Military Session of American Society for Research in Psychosomatic Problems held in Detroit in 1943, there are extended discussions of various psychosomatic medical problems.

"Psychosomatic Medicine" is the title of a work by Dr. C. Binger, published in the *New York Medical Journal* in 1945, the second of his articles on this subject.

Most of the material urges the importance of accurate and progressive records, including photographs showing changes. In some of them equality and fairness to the employer and employee are urged, but in general the articles on this subject by those who are authorities discuss the influence of the mind on the healing of trauma, on disease and illness, and especially the influence of the mind which may provide for a beginning of disease as a result of effect on the endocrinal system and on tissue.

There is a relationship between accidents and emotions, of course. It is this relationship which seems to be illustrated by persons who appear to have repeated mishaps, which indicates that certain people actually are predisposed to accidents. This is more or less the laymen's view. Psychosomatic medicine explains it as the influence of the mind on the body, or an illustration of the psychosomatic theory in toto.



Dr. Flanders Dunbar, along with Dr. Weiss, noted in *Psychosomatic Medicine*, is of the opinion that a large percentage of accidents in industry are not due to defective machinery, to a physical or mental defect, or lack of skill in the workers, but to the operation of the psychosomatic principle, a mental factor, the personality emotion. Dr. Dunbar holds that up to 90 per cent of all accidents come under this classification.

The injured person exposes himself to conditions which are accident-producing. In the words of psychosomatic medicine, the victim had a compulsion in the accidental direction.

It is this factor which must be taken into consideration in the relationship between employer and employee, and which calls for fair determination in regard to both, and for a proper balance in regard to responsibility from a forensic point of view.

Ulcer of the stomach is held the best illustration of this principle. Of the ulcer cases which involve a considerable percentage of our population, it is estimated that between 75 and 80 per cent are attributable to psychosomatic causes and due to emotional upsets, worry and strain.

Cardiovascular difficulties are another group in this classification. Dr. Dunbar says that this has become a major problem in the Army and is supported in her contention by Army and Public Health officials. For instance, a considerable increase in blood pressure may be caused by fright or by extreme anger. It subsides with the end of the emotional disturbances. But if the latter continues, the hypertension continues.

The abuse of rest as a therapeutic agent has been discussed pro and con for the past two years. There is no doubt but there are few exceptions, but in the majority of surgical, medical, obstetrical, orthopedic cases the rest cure has been greatly abused.

Mitchell's conception has continued to influence the thinking of non-psychologically minded physicians who made diagnoses of these baffling cases as nervous exhaustion, nervous fatigue, neurasthenia and prescribed rest cures, vacations and relaxation treatments. However, Menninger has pointed out a better way to handle these neurotic individuals and that the old method of procedure in the treatment of these neuroses is entirely false in theory and unsound in practice.<sup>9</sup> There may be a few diseases where rest must be first and always first, and I mention tuberculosis. Many physicians recently have suggested that carefully graded activity may sometimes be beneficial in the management of certain patients who suffer from this diseases.

Practically every patient presents a problem of a physical and mental nature—psychomatic.

Prescribed and graded physical and mental activity keep the patient in a much more careful mental state than before. There is ample evidence to indicate that such programs shorten the period of physical disability and lessens the tendency to recurrence of disease.

A release of the atomic forces stored in the great human laboratory should give confidence to the psychologically depressed patient that has been void of self-mastery owing to the ravages of disease, trauma and deformity. The neuroses and psychoses and other evidence of maladjustment on the part of the patient are a result of misdirected energy rather than the lack of sufficient energy. It aims at re-direction of wasted energy and the removal of all interfering inhibitions.

Elbert Hubbard said, "A man is generally down on that which he is not up on." The medical profession should understand the new concepts concerning convalescing

activity which is being practiced and demonstrated in our Army and Navy hospitals. Only in this way can we escape the growing and justifiable criticism that we are abusing rest as a therapeutic agent.

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## MAN VERSUS THE AMOEBIA

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Atlanta

From the time of Adam man has fought, bled and died from unknown killers. It was not until the year 1875 that his hit and run enemy, the *Endamoeba histolytica*, was apprehended.

The man who broke the case was Losch in St. Petersburg, Russia. While he was examining microscopically the stool from a patient with relapsing dysentery, a delicate little creature, feeling its way along, came into his line of vision. As he watched this microscopic animal, almost transparent in appearance, it poured itself into finger-like protrusions as its means of locomotion. In size it exceeded three times that of the red blood cell. Its directional progress across the microscopic field exhibited a very determined personality.

On the death of the patient mentioned, Losch found on autopsy the same tiny creatures in the material from the ulcers in the large intestine that he had previously seen under the 'scope. Four dogs were fed on the ulcerative material, by mouth and rectum.

One became infected and at autopsy revealed the same organisms in the large intestines as previously demonstrated. Later this tiny creature became internationally known as the *Endamoeba histolytica*, the only disease producing amoeba known to mankind.

Let us look a little closer at this enemy of man. Being neither male nor female the amoeba enjoys no marital bliss as it is self-sufficient unto itself. This minute animal has three definite phases in the role of life; namely, the vegetative or active form, the precystic or preliminary stage, and the cystic form or the amoeba of the future.

If the vegetative forms of amoebae found in the acute stage of dysentery were taken into the mouth they would perish as they contact the stomach juices, but if the cysts found in the quiescent stage of amoebic dysentery were swallowed the stomach juices would be unable to penetrate their protective coating.

When the amoebic cyst is swallowed the descent of man begins. After getting the green light through the stomach this invisible divisible cannon ball shoots along the alimentary canal and lands unmolested in the large intestine where it explodes. From this eruption four amoebae emerge that shortly divide into two each, making eight amoebae all told from one cyst.

After liberation these little fellows, being of an entirely carnivorous nature, make a bee line for the mucous membrane of the intestine and just as the breath of the dragon of old scorched the earth, their secretions soften the mucous membrane, thereby making it a simple matter for them to dig in. Once entrenched, they settle down to their way of life.

Some of the amoebae, unable to adjust themselves to their surroundings, become discouraged and start shrinking and secreting a protective wall around themselves in



the hope that they have better hunting next time. This is described as the precystic phase of the amoeba's life cycle. The end result of the precystic stage is the mature cyst which is the only form through which men may become infected with this dread disease. These amoebic cysts fear boiling and drying but delight in moisture and warmth.

There has been a common belief that amoebic dysentery is a tropical disease only. We, the people of the United States, however, must face the fact that the amoeba is a universal traveler and is among us now. Such an authority as Col. Craig, formerly of the U. S. Army, gave us a conservative estimate ten years ago that the amoeba already occupied from five to ten per cent of our population. In 1943 the U. S. Public Health Service recorded 3,285 cases resulting in 161 deaths.

Soldiers have always been the amoeba's prey. During the Philippine Insurrection our boys suffered and died from this bloody fce.

Again in 1916, when Mexico seemed a little too unfriendly and while our soldiers were stationed in El Paso, Texas, the amoeba fell upon them with such force that experts were called in to quell the uprising. Although the population had an occasional sporadic case the amoebic situation lay dormant until after the arrival of Uncle Sam's boys when it developed into an epidemic. The cavalry troops, on account of their horses' attraction for flies, bore the brunt of the slaughter. The rebellion was put down when some of the army produce handlers were found to be carriers and were treated. The end came completely when the last fly winged its way from camp in December.

The amoeba does not depend upon the epidemic for its life everlasting but upon the human carrier and the sporadic case. As

an illustration of the sporadic case, we will sight the synthetic case of one John Doe. John is a healthy fellow enjoying the wide open spaces and the company of his wife in their cottage just miles away from anywhere. Verily, this is his Garden of Eden.

Their only water supply comes from a spring that is lower than their open air comfort. John enjoys the exercise of carrying the water for their use and that of Careless Kate, the cook. Now, Kate being a good trooper, had had a slight digestive disturbance a few months ago and had not even felt the need for a doctor. Alas, from this slight attack she had become an amoebic carrier. Unfortunately, the fact that Kate did not take personal hygiene seriously, combined with several heavy rains that summer and many, many flies, John fell ill.

Unlike Kate, he was taken acutely sick with abdominal pains, nausea, fever, vomiting and bloody diarrhea. Luckily for John, they were able to contact Dr. X from the County of Y.

Doctor X, realizing John's condition was serious, rushed him to the County Hospital where the necessary examinations could be made in the laboratory. Thus these words said by the great Pasteur; namely, "Without laboratories men of science are soldiers without arms", were prophetic in this case. Upon thorough examination of John's stool he was found to have many vegetative forms of *Endamoeba histolytica*. An examination made of Kate's stool showed several amoebic cysts, placing her in the position of a carrier. With both John and Careless Kate taking adequate treatment the amoebae was manhandled again.

Even as the threatening clouds of the worst civilian amoebic epidemic known in our country hovered overhead, Chicago had some beautiful days in the summer of 1933.

Everywhere this great city was aglow. As hostess to the World's Fair she was to hold within her ample arms about eight million five hundred thousand visitors. King Carnival reigned supreme despite the extreme heat and two heavy cloud bursts that flooded the city's sewers.

Overlooking Lake Michigan and nestled in the same block between the fair grounds and business section of Chicago lay two of the older and highly respected hotels. There existed between these two a well established good neighbor policy of sharing the same water supply.

Into the midst of this gay season, while these hotels sparkled with life, love and laughter, disease and death seeped along the corridors. Suddenly there were some guests and employees stricken with nausea, vomiting, bloody diarrhea, abdominal pain, tenderness and fever. Some presented the appearance of a surgical condition and were operated upon. Others improved, and some died. Autopsy findings revealed colonies of *Endamoeba histolytica* in the large intestines and an occasional abscessed liver.

Relentlessly Chicago drew a net around the amoeba. The city fathers called to the colors the city and U. S. Public Health services, the local water, engineering and public works departments. Furthermore, they called on the Department of Preventive Medicine of Iowa State University.

Laboratories were set up in the hotels so as to examine the stools of the guests and employees as soon as possible. The food handlers were examined and re-examined as likely carriers of the disease. Quite a few were infected but not in sufficient numbers to warrant such a crisis as this. Finally, the source of infection was uncovered in the defective plumbing of the larger hotel. A sewer pipe manned by a wooden plug was leaking into the cold water tank. As the summer was so very hot, the guests and employees of both the two neighboring hotels

became heavily infected from the amoebic cysts lying at rest in the joint water system.

From the amoebic epidemic originating in these two hotels, one thousand and fifty cases developed, resulting in seventy fatalities.

In summing up the case of man versus the amoeba, we have given as evidence his quelling of the amoebic outbreak in our soldiers on the Mexican border in 1916, the repelling of the invasion of Chicago in 1933 and the ability to handle countless sporadic cases such as those like John Doe. Thus, we see that man, the hunted, has now become the hunter and has thereby declared open season upon the *Endamoeba histolytica*. For man equipped by civilization with such weapons as meditation, identification, experimentation, medication and sanitation stands guard over his future. While his opponent, the fully entrenched crouching amoeba, obeying no law but that of the jungle, together with its three henchmen—the ignorant human carrier, the house fly and poor sanitation—awaits hourly re-enforcements from overseas. With this, the case of man versus the amoeba rests.

#### HEALTHGRAMS

The tuberculin test indicates the presence or absence of living tubercle bacilli. It "screens out" uninfected persons in survey work and assists in the examination for "contacts" of tuberculous persons. It is important in the collection of epidemiologic data and indicates when an exposed child becomes infected, thus pointing to the source of infection.—SYDNEY JACOBS, M.D., *The Journal Lancet*, March, 1946.

It must be remembered that the returning tuberculosis veteran is, often-times, a difficult patient to treat. Because of his military experience he may have undergone personality changes. He has probably suffered the pangs of homesickness and the annoyance of strict military discipline. Add to these factors a diagnosis of tuberculosis and the chances are that we have a thoroughly depressed individual who rebels against the restrictions that are necessary to effect an arrest of his disease. WILLIAM H. HICKERSON, M.D., *NTA Bulletin*, December, 1945.

*The JOURNAL would like to record the scientific work of Georgia physicians. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*



## PRESIDENT'S PAGE

### POLIOMYELITIS

To enter controversial discussion in a field where one is not qualified by his training as an expert usually is offering one's neck to the stroke of the gold-plated axe. However, the Associated Press report which showed that the entire country presents the worst wave of infantile paralysis since 1916, which has reached epidemic proportions in some localities of the South, West, and Middlewest, leads me to express myself in support of the action of the Georgia Department of Public Health in establishing quarantine regulations restricting the movement of individuals who have come into Georgia from areas which show greater than average prevalence of this dread disease.

While these regulations seem to be pointed directly against Florida, and from the information or lack of information carried in the Preventable Disease News Letter of the Florida State Board of Health dated July 1, 1946, we would be led to believe from the quotations of the authorities listed that all means of quarantine against this disease are stupid backward steps into medieval days. Nonetheless, the United States Public Health Service reports a cumulative total of 5,454 cases throughout the nation for the present year, the highest total since 1916.

The News Letter, quoted above, states Florida has had 226 cases as of July 1, but on August 8 the Associated Press reports Florida to have had 385 cases. Does not an increase of 159 cases in the past month justify the action of our Board of Health in restricting the activities of individuals

from exposure areas until it is certain they do not harbor a danger to individuals with whom they may associate?

I quote from an editorial in *The Journal of the American Public Health Association*: "If inapparent and subclinical infections are considered, as well as clinically recognized cases, frequency of traceable contact is of the same order as that which can be established in studies of diphtheria, scarlet fever, meningococcus meningitis or bacillary dysentery. It is not yet clear whether effective contact involves transmission through the air by droplet nuclei, droplets or sputum particles or mechanical transmission from objects contaminated by oropharyngeal secretions. Evidence that the virus may travel from one person to another by more remote channels is lacking. Until new evidence is forthcoming, public health workers would be well advised to stick to the simple and well established concept that polio is principally, if not entirely, spread by direct and intimate contact. The mystery of its behavior lies in the fact that we have such a large number of subclinical cases (well, healthy carriers) during an epidemic."

Thus from the evidence at hand I, as an individual and as President of the Medical Association of Georgia, express my complete confidence and the confidence of the Association which I represent in the advisability of whatever measures Dr. T. F. Abercrombie as director of the Georgia Department of Public Health deems advisable to take regarding this disease.

RALPH H. CHANEY, M.D.

**THE JOURNAL**

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

SEPTEMBER, 1946

## TRIBUTE TO OUR CENTENARIAN—

DR. THOMAS DICK LONGINO

Tonight<sup>1</sup> we are celebrating a most unusual event. In two more days, on September 7, one of our members will be one hundred years old. It is said that the medical profession as a group are the shortest lived people in the world, preachers and teachers being the longest. We can easily believe that we belong to a group which lives the shortest time when we contemplate the havoc played in our ranks in recent months and years, especially by cardiac disease. The average longevity of man at present is reckoned at 65 years, but think how many of our friends have not attained this age. So that when a doctor lives to be one hundred years of age, he helps materially to bring up our average.

Dr. Thomas Dick Longino, whom we honor tonight, was born September 7, 1846, in Campbell County, Georgia, six miles from the town of Palmetto, and received his preliminary education in the county schools. When asked why he studied medicine, he said that no member of his family ever was a doctor, but that he took up the profession because of his desire to help somebody. Seeing a Negro afflicted with nystagmus worried him so much that he definitely decided to become a doctor, although he did not take up the study of ophthalmology.

He studied at the Medical College of Georgia, in Augusta, where he graduated in 1870, one of his classmates being my wife's father, Dr. J. S. Horsley. Among Dr. Lon-



THOMAS DICK LONGINO, M.D.

gino's teachers were some of the best known Georgia physicians and surgeons of the day, such as the Fords, Dugas (of Dugas' sign), Campbell, president of the American Medical Association, Eve and Doughty. Dr. Longino began the practice of medicine in Palmetto in 1870, and came to Atlanta in 1886. Altogether he practiced for 55 years, when his eyesight became so weak he could not read a thermometer. He has been a member of this society since 1898, a period of 48 years.

When Dr. Longino was born, anesthesia was only four years old, while antiseptic surgery was not announced to the world for 21 years, in 1867, although it was a long time after that before Lister's discovery became universally adopted. During the lifetime of this beloved member of the society our country has been engaged in five wars, although we are counted a peace-loving peo-

1. Address before the Fulton County Medical Society meeting, Atlanta, Sept. 5, 1946.



ple—the Mexican War in 1848 (Dr. Longino does not remember much of that), Civil War, 1861-65, Spanish-American, 1898, and the two World Wars. He served nine months in the Civil War (purists claim it should be called the War Between the States, but that is too big a mouthful), and was 18 years old, “young and spry,” when he joined Wheeler’s cavalry after Sherman had marched through Atlanta.

The doctor has always been interested in politics and in the public health of his adopted city, and besides serving on the Atlanta City Council for three terms, he was at various times Mayor of Palmetto, Mayor of West End, when West End was a separate corporation from Atlanta, and Mayor pro tem of Atlanta. A large part of Dr. Longino’s practice was carried on in West End where he was the highly esteemed physician for many of the leading families, and enjoyed a lucrative practice.

It was in 1899, if Dr. Longino’s memory serves him correctly, that he introduced the first bond issue bill into Atlanta’s city council, for one million dollars, but it failed to pass, although a three million dollar bond issue was passed five years later. He inaugurated the first health department of the city, and had the first health officer installed, Dr. J. P. Kennedy, who held the office for the rest of his life, more than forty years. As a member of Atlanta’s council Dr. Longino belonged to the Grady Hospital Board of Trustees, and always took an active part in its proceedings. He had decided opinions about public matters, and in the offices he held he displayed absolute honesty, fairness, courage and independence.

His first wife died after they had been married five years. To this union was born one son, Dr. Thomas C. Longino, a graduate of the University of Virginia. This junior physician was a captain in the Medical

Corps of the United States Army, and served in the Philippines from 1900 to 1903. He became a member of this society, and practiced in Atlanta until 1911 when he died at the age of 37. Young Tom Longino will be remembered by the older members of the society as a man of magnetic personality and an excellent physician. Dr. Longino’s second wife lives with him in Decatur. They have three living sons, Olin Harrington Longino, Brigadier General in the United States Army, and Hinton F. Longino and Joe Wheeler Longino, of Atlanta. Dr. Longino’s nephew, Dr. Dick Longino, is a member of the Fulton County Medical Society.

When I asked our centenarian member what he thought of present-day medicine he replied that there must be some change in it, and when asked what he meant by that he said that better means must be found to care for poor people. We congratulate him upon reaching this lofty birthday with such an enviable record of service to humanity. It is something for him and all of us to be proud of, and a great inspiration. He attributes his long life to altruism, and we can well believe that this is true. It would seem that the more one thinks of his fellowmen and the less he thinks of himself the longer he should live, so that we all may profit by the life of this grand member of the Fulton County Medical Society.

FRANK K. BOLAND, M.D.

#### FAMOUS GEORGIA DOCTORS

Students of Georgia’s medical history, which holds many illustrious names, are aware, no doubt, of the work of Dr. Milton Antony. But we must own that our first knowledge of him came from an article in last week’s issue of the *Monticello News*, which notes that few persons in that city and in Jasper County, where he first practiced his profession, have even heard of him.”

Dr. Antony’s career was relatively brief but rich in service and in honor. Born in 1789, he died at the age of 50. Among his operations which evoked international interest were the first resection, or partial removal, of a diseased rib and the first reduction of a fracture by

pulley-and-weight traction. He was a founder of what is now the Medical College of the University of Georgia, also of the American Medical Association, and was editor of the Southern Medical and Surgical Journal, the first publication of its kind in this region. While the greater portion of his professional life was spent in Augusta, he was distinguished throughout the nation.

From the days of Liberty County's Dr. Lyman Hall, who was a signer of the Declaration of Independence, Georgia has been noted for physicians of strong character and high attainments. Dr. Paul Fitzsimmons Eve, of Augusta (1806-1877), is credited with being the first American to perform the operation for removal of the uterus. Famous also as a military surgeon, he was with the Poles in their revolt against Russia in 1831, with the United States expeditionary forces in the Mexican War, and was chief surgeon of General Joseph E. Johnston's army in the War Between the States. Most renowned of Georgia's physicians was Dr. Crawford W. Long, who first discovered and demonstrated the use of ether as an anesthetic, in a surgical operation performed at Jefferson, Jackson County, March 30, 1842. Dr. Robert Battey, of Rome (1828-1895), was famous alike in America and in Europe for the operation which bears his name and for other contributions to the science and art of surgery.

These were some of the pioneers and builders of a shining tradition. The resourcefulness, the courage, the character and the skill for which they stood are revealed anew in Georgia's medical profession today.—*Atlanta Journal* editorial, Aug. 25, 1946.

### IMPORTANT BOOK FOR THE MEDICAL PROFESSION

An astounding expose of the machinations of a small clique of leftist-minded government officials and professional "do-gooders" bent upon foisting on the American people a tax-supported system of Federally-dominated medical, dental and hospital care is contained in a 196-page book, "Compulsion the Key to Collectivism," just published by the National Physicians Committee for the Extension of Medical Service.

The study reveals an amazing chain of circumstances in support of the contention that a deliberate attempt was made to manipulate the recently-ended public hearings of the Education and Labor Committee of the United States Senate on S.1606 so that the Congressional inquiry might be utilized to create a false impression of public support for the Wagner-Murray-Dingell bills.

Of the importance of the issue treated, the book states in part: "The principle at issue is the one around which all others revolve. Compared to it the decisions of the United Nations, and the signing of treaties of peace are of passing conse-

quence. Actually, splitting of the atom and the development and control of atomic energy are of lesser importance. In this matter we are dealing with the essence which is the *Soul of Man*. To meet the requirements of this new, strange world, the minds of men must be free, the souls of men must be unfettered."

In the foreword, the book states, "Already we are confronted with the establishment of controls and 'lusts for power' never before known in this country . . . There is just one thing that is essential for the American people to understand: communism, fascism, nazism are not mere matters of terms or definitions. They result from the establishment of centralized controls and the operation of mechanisms of administration . . . If the Wagner-Murray-Dingell proposals were enacted into law they would introduce a compulsory tax to pay for a compulsory service—medical, dental and nursing care—directly affecting the most vital and most sacred functions of each individual citizen of the United States . . .

"During the last twelve years we have witnessed the encroachments that are leading, even now, to a creeping paralysis of our social and economic functions. Herein a plot is shown. The designs of the schemers is made crystal clear. It is not merely a matter of medical care—or the regimentation of the medical profession that is at stake. It is our country—our beliefs, our concepts—our very souls that are involved."

It is pointed out in the book that when the proposed legislation was introduced in the Senate on Nov. 19, 1945, a ruse was resorted to in order that the bill might be referred to the Committee on Education and Labor, of which Senator James E. Murray, of Montana, one of the authors of the measure, is chairman. This was accomplished through omission in the bill of any provision for special revenue to finance the estimated four billion dollar expenditures necessary to carry out the revolutionary program.

Immediately the leftist groups, aligned with the propaganda campaign to foist political medicine on the people of the United States, began preparations for dominating the forthcoming public hearings of the Senate Committee on Education and Labor. Witnesses permitted to testify at the hearings were selected by a carefully chosen "screening committee," friendly to the proposed legislation, with the result that the final record showed an average of two witnesses appearing in support of Title II of the Wagner-Murray-Dingell bills for every one permitted to appear in opposition to the Compulsory Health Insurance provision of the measure—this despite urgent requests from hundreds of practicing physicians for an opportunity to be heard in opposition.

The list of witnesses in favor of "Political Medicine" was heavily loaded with Federal pay-rollers and leftist group representatives—"a perfectly normal pattern of bureaucrats at work in



quest of more and more power over the lives of the people," according to the National Physicians Committee.

A chapter of the book reviewing the historic background of the agitation for Compulsory Sickness Insurance in the United States asserts that the Wagner-Murray-Dingell bills are not of American conception, but are patterned after a model formulated by the International Labour Organization, established in 1919 at Basel, Switzerland, as a function of the League of Nations. Testimony during the recent Senate Committee hearings in Washington elicited the information that a major portion of the Wagner-Murray-Dingell bills (S.1606—H.R.4730) was written by Isadore Falk, United States delegate to the I. L. O. and Director of Research and Statistics for the Social Security Board.

Both the historic narrative in the book, and the voluminous excerpts from the hearings, develop the astounding fact that a major portion of the agitation for *political medicine* in the United States springs from "public welfare" agencies of the Federal Government, and that to an amazing degree these agencies are dominated by men and women long recognized as sympathetic to the philosophy of state socialism. From this source, over the years, an imposing array of leftist organizations has grown to disseminate government propaganda for such insidious freedom-destroying proposals as contained in the Wagner-Murray-Dingell bills.

Reverting to the public hearings before the Senate Education and Labor Committee, presided over by Senator James E. Murray, of Montana (one of the sponsors of the legislation), the book relates how the meticulous stage-setting for the hearings was rudely upset on the opening day by the dramatic action of Senator Robert A. Taft, a member of the committee, who strode from the committee room after a verbal tilt with Senator Murray.

Pages of testimony of proponents of political medicine and cross-examination are printed to show that some of the witnesses had not even read the bill, that others were unfamiliar with the provisions of the measure and even with the prepared statements they were reading into the record. On the other hand, men prominent in the medical and dental professions and others outstanding in religious and business circles presented documented testimony in support of their contention that compulsory, tax-supported sickness insurance not only was not necessary in the United States, but that if such a basis of centralized control were once established the collectivists would almost certainly take over every other area of human activity and endeavor.

An illuminating chapter of this remarkable document blasts the much misused draft rejection statistics, which have been distorted by advocates of political medicine in an effort to discredit the type and scope of medical care available in the United States. The controversial sta-

tistics are analyzed and shown utterly to lack the significance attributed to them by the compulsory health insurance proponents. Through testimony of competent witnesses, before the Senate Committee it was established that the actual number of military rejectees whose physical deficiencies might possibly have been avoided by better medical care in infancy or youth was about 31 per cent of the number so glibly charged to the "breakdown of American Medicine."

Congressman Arthur L. Miller, of Nebraska, himself a practicing physician of long experience, testifying regarding the distortion of draft rejection statistics, reminded the Senate Committee that the United States has the finest hospitals, and the most highly developed medical and surgical technics in the world. He warned that the complete revolution of medical practice, medical education, hospitals and research under a Federally-administered compulsory health insurance program would bring about progressive deterioration and ultimate collapse of the great gains medicine has made under the American free enterprise system.

"Compulsion the Key to Collectivism" tears the mask of pretense from a designing group of leftist-minded persons who, in the guise of altruism, would fasten upon the American people a ruinous system of regimentation from which escape would be well-nigh impossible.

It records the frustration of an ill-conceived plan to pervert the high purposes of a Congressional function of vital importance to the welfare of every American citizen.

It chronicles the ignominious collapse of another frantic effort to "put over" in the United States a compulsory, tax-supported medical and dental care program of the type that has failed miserably where tried in foreign countries.

It provides the American people with factual information that should warn them against renewed efforts of the collectivists in this country.

## PENICILLIN FACTS AND RUMORS

Recent articles in periodicals of wide circulation have created unwarranted fears in the minds of the public concerning the value of penicillin and other new remedies.

Unfortunately, some of the articles are factually incorrect. The creation of doubts and fears in the minds of patients concerning the therapy which they receive may prevent the full realization of benefits from treatment.

Physicians should be in a position to give their patients the facts concerning penicillin and to allay any doubts or fears created by these publications. Briefly, the facts concerning the latest developments in penicillin therapy are as follows:

1. Commercial penicillin has consisted of varying mixtures of one or more of the five known fractions, F, G, X, K and dihydro F.
2. Penicillin K is apparently rapidly destroyed

or eliminated in the body, and therapeutic levels are not achieved or maintained in the body fluids following ordinary doses.

3. Commercial penicillin now available is predominantly penicillin G, which is known to be effective although some of the penicillin produced for a few months in 1945 may have had relatively less G and more K than previous or subsequent batches.

4. As far as facts are available, penicillins F and X are as active clinically as penicillin G. Further research will be necessary to define their usefulness with preciseness.

5. Since precise methods are not available for the routine determination of the quantities of each fraction in each bath of penicillin, the National Research Council has recommended increased dosage of penicillin as a safety precaution, particularly in the treatment of syphilis, in which the end result of therapy cannot be evaluated for a long time.

6. Although bacteria have been made resistant to penicillin in the test tube, development of clinical resistance has not become a problem. Such an eventuality may be prevented, in part, by giving adequate and not minimum doses of penicillin.

7. All penicillin and penicillin pharmaceuticals currently on the market have been examined and certified as to safety and efficacy by the United States Food and Drug Administration.

8. It is possible that natural or synthetic variations of the penicillin molecule will result in the development of a clinically better penicillin. None better than penicillin G is now available.

While it is realized that the rapid developments now being made in therapeutics make it increasingly difficult for busy physicians to read and evaluate the many scientific articles appearing in hundreds of periodicals, the physician can keep himself informed of the more important developments through a study of the Reports of the Council on Pharmacy and Chemistry of the *American Medical Association*, from whom this report was received. Furthermore, the Council office and its personnel are always ready to answer inquiries and furnish information on drugs and therapeutic agents. Physicians, by using this service, can allay the fears of their patients who have come to doubt the efficacy of penicillin even when properly used.

#### KNOWLEDGE AND CHANCE

We have all heard this: "How did we manage to get along before we knew about vitamins and had all of these new fangled notions about food? What was good enough for grandpappy is good enough for me!" The point is this: while grandpappy was living to the ripe old age of ninety, thousands of potential grandpappies were filling small and untimely graves in community churchyards. Many of the health hazards of that day were unrecognized, but this made them no less dangerous. Knowledge releases us from the rule of chance and gives us a rational guide to health and longevity.—WALTER WILKINS, Surgeon, U.S.P.H.S., *Mississippi Doctor*, April, 1945.

#### DR. R. HUGH WOOD DEAN OF EMORY'S MEDICAL SCHOOL

Appointment of Dr. R. Hugh Wood, physician-in-chief at the Emory University Hospital, as dean of the Emory University School of Medicine, has been announced by Dr. Goodrich C. White, Emory president. Dr. Wood succeeds Dr. Eugene A. Stead, Jr., who resigned recently to accept a position at Duke University.

A native of Virginia, Dr. Wood received his medical training at the Medical College of Virginia, Richmond. He completed his internship at St. Elizabeth and Memorial Hospitals, Richmond, Va., and Peter Bent Brigham Hospital, Boston, Mass.

In 1924, Dr. Wood came to Atlanta as resident physician in the Emory Division of Grady Hospital. After two years in that position, he entered private practice in association with Dr. James E. Paullin. This association continued until 1934, when he began independent practice of internal medicine.

Dr. Wood was commissioned as an officer in the Army Medical Corps in 1942. Appointed chief of medical service for the 43rd General Hospital (the Emory Unit), he served with the hospital in North Africa and Italy. Returning to the United States late in 1944, he served for a few months at Fort McPherson and was then named Chief of Medical Service at Lawson General Hospital, a position he held until his release from active duty in October, 1945. He left the Army with the rank of Colonel.

Long an outstanding practicing physician, Dr. Wood has been associated with the faculty of the Emory medical school since 1924, when he was first appointed an instructor in medicine. Upon his return to civilian life, he became associate professor of medicine in the medical school and physician-in-chief of the Emory Hospital.

The author of numerous publications on medical subjects, Dr. Wood is a Fellow of the American College of Physicians, and the American Medical Association, and a member of the Southern Medical Association and the Medical Association of Georgia, as well as the Fulton County Medical Society. His social and professional fraternities include Sigma Pi and Omega Upsilon Phi.

#### A.M.A. JOURNAL CAUTIONS AGAINST USE OF MINERAL OIL IN FOOD

High prices and the scarcity of edible vegetable oils have caused many restaurants to use mineral oil in food, according to the August 24 issue of *The Journal of the American Medical Association*, which warns that this practice is harmful to patrons. *The Journal* says:

Attention has been called recently to the occurrence of fecal incontinence due to the ingestion of excessive quantities of mineral oil by unsuspecting patrons of restaurants where mineral oil has been substituted for edible oils in salad dressings. The Council on Foods and Nutrition called attention to the harmful effects of mineral oil in foods in the following paragraph:

It has been shown that the ingestion of liquid petrolatum is capable of interfering seriously with the absorption of carotene, vitamin D, calcium and phosphorus and vitamin K. The effects of its prolonged use have not been thoroughly investigated, but there is sufficient evidence of possible harmful effects to justify the conclusion that its indiscriminate use in foods or in cooking is not in the interest of good nutrition, and any such use should be under careful supervision of a physician.

In reply to inquiries about the legality of mineral oil in salad dressings the Food and Drug Administration has expressed the opinion that "mineral oil salad dressings must be regarded as adulterated under the Federal Food, Drug and Cosmetic Act under any form of labeling employed." Mineral oil should certainly not be used except under the supervision of a physician familiar with the problems involved and should not be used indiscriminately in foods.



## GEORGIA DEPARTMENT OF PUBLIC HEALTH

### MURINE TYPHUS FEVER CONTROL IN GEORGIA

Typhus control activities in Georgia were expanded through financial assistance of the U. S. Public Health Service during the latter part of 1945.<sup>1</sup> The expansion of services consisted of operating control programs, through local health departments, in twenty-three counties. Counties operating control programs are: Appling, Bibb, Bulloch, Burke, Chatham, Coffee, Colquitt, Crisp, DeKalb, Dougherty, Early, Fulton, Glynn, Jenkins, Laurens, Richmond, Screven, Telfair, Terrell, Tift, Toombs, Ware and Worth.

Principal control measures applied are DDT dusting of rat runs and rat eradication in business establishments and selected urban and rural residential areas. In several of the counties and cities a program of "vent-stoppage"<sup>2</sup> of business establishments is conducted as a permanent rat and typhus control measure. While rat eradication and vent-stoppage measures have been currently applied in many counties of Georgia since the Typhus Control Service was organized in 1937, DDT dusting was added to the State program for the first time in 1945.

DDT, in various forms, has proven effective in the control of many insect pests. As a typhus control measure, DDT is used in powder form, containing at the present time 10 per cent DDT and 90 per cent pyrophyllite (talc). The material is dusted in defined rat runs of buildings, rather than over the entire floor area. Rats passing through the dust apparently get DDT on their feet and bellies in sufficient amounts to kill the fleas on their bodies. Rats passing through the DDT dust spread the material along their runs and undoubtedly carry a small amount back to their nests. This also kills the fleas that come in contact with the DDT dust in the rat runs and nests. Although these factors have not been proven in all details, it is evident that DDT dust is effective by the fact that rats caught before and after dusting show a marked reduction in flea indices. This is substantiated in part, at least, by the results of the first six months operations in twenty-three counties during 1946. During this period a reduction was noted of 72.7 per cent in the flea index of 1,198 rats examined in DDT dusted areas, as compared with 1,126 rats examined in undusted areas. By individual counties the reduction in flea index due to DDT dusting amounted to as high as 98 per cent. In addition to these data, research work by the U. S. Public Health Service, Technical Development Division of the Communicable Disease Center, indicates that DDT dust, when applied to rat runs as previously described, is an effective and practical measure of controlling rat fleas.

Since murine typhus fever is transmitted from rat to rat, to man by infected rat fleas, and DDT dust is an effective control measure for rat fleas,

we should therefore be justified in assuming that DDT dust properly applied to rat runs, is also an effective typhus control measure. It is on this assumption, primarily, that DDT dusting for murine typhus fever control is currently conducted in twenty-three counties of Georgia and by eight other Southern states. Until conclusive data are obtained from DDT dusting operations in Georgia and other states, we must view this phase of the typhus control program as an investigative study rather than as a tried and proven typhus control measure. It is interesting to note, however, that for the first six months of 1946 there were reported for the entire state 206 typhus fever cases, as compared with 267 typhus fever cases reported for the same period of 1945. This is a reduction of 61 cases or 22.8 per cent in 1946, as compared with 1945. On the basis of the twenty-three counties operating typhus control programs for the first six months of 1946, 87 typhus fever cases were reported for this period as compared with 138 cases reported for the same period of 1946. This is a reduction of 51 cases or 37 per cent in 1946 as compared with 1945. Furthermore, comparing the twenty-three DDT dusted counties with the undusted counties of the State reporting typhus fever cases, we note that the undusted counties show a total reduction of 14.8 per cent in the number of typhus fever cases reported during the first six months of 1946 as compared with the same period in 1945. The reduction in the DDT dusted counties, as compared with the undusted counties, is therefore 22.2 per cent. On the basis of individual counties, we note that Chatham County reported 11 typhus fever cases during the first six months of 1946 and 24 cases for the same period in 1945. This gives a reduction of about 54 per cent in 1946 as compared with 1945. Bibb County, operating a typhus control program consisting of vent-stoppage of business establishments as well as DDT dusting and rat eradication, reported 7 typhus fever cases during the first six months of 1946 and 18 cases during the same period in 1945. The reduction noted is about 61 per cent in 1946 as compared with 1945. Although these data may present encouraging results, we must further consider that on the basis of the seasonal variation of murine typhus fever only about 25 per cent of the total number of typhus fever cases reported for the State each year are reported during the period from January to July. For this reason it is too early at this time to make any predictions as to the effectiveness of DDT dust and rat eradication on the control of murine typhus fever.

From previously reported epidemiologic studies in Georgia,<sup>3</sup> the following criteria were established for purposes of selecting areas in the several counties for DDT dusting and rat eradication operations:

(a) All rat infested business establishments

in cities, towns and rural areas. This includes public buildings, churches, schools, apartment buildings and rooming houses, food handling establishments, etc.

- (b) All dwellings and out-buildings within a city block of location of recent residential typhus fever cases.
- (c) All dwellings and out-buildings on farms within a radius of about three-fourths of a mile of the location of residential typhus fever cases.
- (d) Urban and rural areas in which typhus infected rats are trapped.

The above criteria, for the selection of areas to currently apply typhus control measures, are believed to be justified as a scientific approach to the disease problem. By selecting areas of potential foci of infection, the cost to local and state health departments for applying control measures may be kept at a minimum.

For the first six months of 1946, 54,347 premises were treated with DDT dust, requiring approximately 275,067 pounds, or an average of 4.7 pounds per premise.

Rat eradication consists of poisoning rats on premises previously treated with DDT dust at intervals of about three months. Principal types of rodenticides used are 1080 (Sodium Fluoracetate), Red Squill, and ANTU (Alpha-naphthylthiourea). Due to the extreme toxicity of 1080 to human beings and pet animals, this rodenticide is restricted principally to business establishments whereby the material in the form of poison water may be placed under lock during the period of exposure to rat infestation. Red Squill, in the form of bait, is used most universally due to the fact that it is the safest of all commercial rodenticides to human beings and pet animals should they accidentally ingest the poison. ANTU is used in the form of bait and also mixed with DDT dust. In the form of bait it is prepared and distributed in a manner similar to Red Squill bait. As a dust, it is mixed in the ratio of about 20 per cent ANTU and 80 per cent DDT dust containing 10 per cent DDT and 90 per cent pyrophyllite. The mixture is dusted in defined rat runs resulting in the destruction of a large percentage of the Norway rats and fleas that come in contact with the material. The high cost of this mixture of rodenticide and insecticide is prohibitive at the present time for large scale operations. The number of premises treated with the several types of rodenticides during the first six months of 1946 was about 24,000.

The evaluation of DDT dust is determined principally by rodent investigations. These investigations include rate ectoparasite and rat blood serologic studies. Rat ectoparasite studies indicate the effectiveness of DDT dusting operations by a comparison of rat flea indices on rats trapped in DDT dusted premises and undusted

premises. Rat blood serologic studies indicate areas of typhus infected rats for applying control measures, and the effect of DDT dusting on the typhus infection rate in old and young rats. The determination of rat blood serologic studies is by the "complement fixation test." This test does not necessarily indicate that a positive reaction is conclusive of the infection in the rat at the time blood was taken, but merely indicates that the rat was probably infected at some period during its life. The number of rat blood specimens examined during the first half of 1946 was 1,670 of which 608 or 36.4 per cent of the rat blood specimens were positive to typhus fever. The positive complement fixation titres of rat blood specimens varied from 1:4 to 1:024 plus.

It is believed that with the advent of the insecticide DDT, and rodenticides 1080 and ANTU, new weapons are added to the list of existing control measures for combatting murine typhus fever.

Roy J. Boston, *Director,*  
Typhus Control Service.  
Division of Preventable Diseases.

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#### ARMY TO RECALL 1,000 NURSES, 100 MEDICAL ADMINISTRATIVE OFFICERS

Recall quotas for 1,000 former Army Nurse Corps officers and 100 additional Medical Administrative Corps officers were announced by the War Department.

Major General Norman T. Kirk, the Surgeon General, said the recall of officers to active duty on a voluntary basis was necessary to insure the best possible care to some 90,000 patients remaining in Army hospitals throughout the world.

Other corps in the Medical Department which have been authorized recall quotas are Medical Corps, 100; Dental Corps, 100; Sanitary Corps, 50; Veterinary Corps, 25, and dietitians, 50. The first recall quota of 200 Reserve and National Guard officers authorized for the Medical Administrative Corps last spring has been met.

In general, all officers who return to active duty must qualify for general duty and be available for overseas duty. They will replace personnel eligible for discharge. As former officers, they must have an efficiency score of at least 35 to return in company grade and 40 points to return in field grade.

Nurses who come back into service will be given their choice of two categories. They may don their uniforms again to serve until relieved at the convenience of the government or for two years. Medical Administrative Corps officers may sign up for 12, 18, or 24 months or an unlimited length of time.

Former Army nurses have evidenced great interest in returning to active duty. Already, about 1,500 have notified the War Department they are ready to trade civilian life for further military duty. They will not be considered if they are married or have dependents under 14 years of age.

All applicants desiring recall for extended active duty should obtain application blanks from the Adjutant General, Washington 25, D. C., or any Army Recruiting Stations, Camps, Posts, or Stations.



## GEORGIA STATE NURSES' ASSOCIATION

### 1946 ANNUAL CONVENTION OF GEORGIA NURSES—MACON

Much interest is already seen in the coming annual joint conventions of the six state nursing groups scheduled to be held November 3-4-5-6, 1946 at Macon. The Hotel Dempsey will be headquarters. Most of the meetings will be held at the Mulberry Street Methodist Church. Mrs. Irma S. Marsh, President of the Sixth District, Milledgeville State Hospital, Milledgeville, is chairman of local arrangements.

The State Nursing Groups participating in the program are as follows:

40th Annual Convention of Georgia State Nurses' Association and Her Private Duty Section.

20th Annual Session, Georgia League of Nursing Education.

21st Annual Session, Georgia State Organization for Public Health Nursing.

3rd Annual Session, Georgia Association of Industrial Nurses; and

6th Annual Session of the State Nursing Council.

*Convention Theme:* "Now Is the Time for Forward Motion—Progress Will Then Be Inevitable."

Highlights of the program include:

Panel on *Expected Developments in Georgia Nursing*. This is the first part of the program scheduled for 2:00 P. M. Sunday, November 3. Speakers from Nursing Education, Private Duty, Public Health, Industrial Nursing, Legislation and other groups will participate.

The alumnae dinner is scheduled for 7:00 P. M. Sunday, November 3, where the "*Question of the Alumnae as the First Unit of Professional Nursing Organization*" will be discussed. Business sessions, group luncheons and the public session will crowd the program for Monday, November 4.

Miss Eugenia Spaulding, one of the national guest speakers, will contribute to the public session program at 8:30 P. M. Monday, November 4, on the topic "*Nursing in Relation to Current Social Legislation*." She will also discuss, "Guidance in Schools of Nursing."

Mrs. James N. Brawner, Sr., Atlanta, chairman Student Nurse Enrollment Georgia Federation of Women's Clubs, will be a speaker at the League Luncheon on Monday, November 4. She will tell why lay participation in nursing education is helpful and necessary.

The Public Health, Industrial and Private Duty groups will have national guests and have outlined panels, roundtables and luncheons to discuss the issues of the hour, such as "*Teamwork in Industrial Health*," "Organizations and Program of State and Local Industrial Groups";

"Educational Opportunities in Georgia for Industrial Nurses"; "Personnel Practices and Policies"; "Lay Participation in Nursing."

A banquet and dance will be a special feature of Tuesday evening, November 5. Exhibits from publishers of nurses' textbooks and from students in schools of nursing, public health, industry, and others, will be on display.

The greatest attendance since the year of organization is expected.

### A. N. A. BIENNIAL

#### ATLANTIC CITY—SEPTEMBER 23-27, 1946

Georgia nurses will attend the American Nurses' Association Biennial Convention to be held September 23-27, 1946, at Atlantic City, New Jersey.

Issues of vital importance to all nurses and to the public they serve promise to attract over 12,000 to the convention. Among the questions which may be discussed are personnel problems, collective bargaining, federal legislation as it relates to nursing, counseling and placement, structure study, membership in A. N. A., the relation of practical to professional nursing and social security for nurses.

Georgia will have at least 19 voting delegates, and many more plan to attend. The National League of Nursing Education and National Organization for Public Health Nursing meet jointly with A. N. A.

### WHERE ARE THOSE NURSES?

With the rapidly expanding programs of health, hospital care, veterans service, etc., it is increasingly important that all schools of nursing in Georgia enroll students to capacity so that the great shortage of professional nursing service will be alleviated in the shortest possible time by more graduate nurses.

Some Georgia hospitals are having to close beds due to lack of sufficient nurses and other personnel to care for them.

*Doctors—Auxiliary Members*—and all citizens are urged to assist in every way possible with the campaign to enroll 500 qualified students for the fall classes in Georgia schools of nursing.

### ARMY MEDICAL LIBRARY AIDS VETERANS ADMINISTRATION

Under the reorganization of the Veterans Administration its medical libraries have been faced with increased demands for recent medical literature. The Army Medical Library has offered its cooperation by transferring from its stock of duplicates such books and periodicals as are in excess of its actual or anticipated needs, and is supplementing the reference service of these libraries through inter-library loan, reference and photoduplication services. Eighteen Veterans Administration libraries have been assisted to date through the contribution of books and periodicals.

## NEWS ITEMS

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, August 6. Program: Kodachrome Slides by Dr. Reiffer.

Dr. W. W. Blackman and Dr. John M. Walton, of Atlanta, formed a partnership on August 1 for the operation and ownership of Blackman Sanatorium, under the new title of Blackman-Walton Sanatorium. It will continue to be conducted as a medical and physiotherapeutic hospital.

Dr. Fred Denton, Augusta, member of the faculty of the University of Georgia School of Medicine in the department of bacteriology and public health, recently addressed the city playground staffs at the City Hall. The address was made in connection with Nature Week held at the local parks, Augusta.

Dr. A. H. Frye, Jr., Griffin, announces the opening of his office with his father at 110 North Hill Street, Griffin. Practice limited to the diseases of women, and surgery.

Dr. Jackson T. Giles, Griffin, recently released from the Navy Medical Corps, has opened offices for the practice of medicine at 127 East Solomon Street, Griffin.

Dr. O. T. Gower, Cordele, announces his release from the Medical Corps of the U. S. Army and the opening of his offices for the practice of medicine and surgery in the First State Bank Building, Griffin.

Dr. Charles William Hock, Augusta, assistant professor of medicine in joint charge of the Gastrointestinal Clinic, the University of Georgia School of Medicine, announces the opening of his office in the University Hospital, Augusta. Practice limited to gastroenterology.

R. C. Coleman, joint secretary of the State Examining Boards, advises that a medical directory will be published of all licensed physicians in this State who furnish the information requested of them in a letter to be mailed them.

The directory will carry the names, addresses and specialty for all licensed physicians registered for the current year, and also a copy of the Medical Practice Act. A copy will be mailed to all physicians registered.

The office of the Joint Secretary will appreciate the cooperation of the profession in making this directory as complete as possible. If any physician fails to receive a notice please contact Mr. Coleman at his office in the State Capitol, Room 111, Atlanta.

Dr. Marion McH. Hull, Atlanta, announces the removal of his office to 15 Fourth Street, N. E., at West Peachtree, Atlanta.

Dr. Alex P. Jones, formerly a member of the staff of Emory University Hospital, Atlanta, announces the opening of his offices at 200 Park Building, Griffin, for the practice of medicine.

Dr. H. T. Kennedy, Warrenton, announces his return from the Medical Corps of the U. S. Navy and has resumed his practice of medicine with offices over Steine's Store, Warrenton.

Dr. Polk S. Land, Columbus, recently released from the Army Medical Corps, has resumed the practice of medicine at Columbus.

Dr. William P. Leonard, Atlanta, announces the removal of his offices to 305 Doctors Building, 478 Peachtree Street, N. E., Atlanta. Practice limited to general surgery.

Dr. T. C. Davison and Dr. Floyd W. McRae, both of Atlanta, recently attended the meeting of the American

Association for the Study of Goiter, held in Chicago. The next meeting of this association will be held at the Biltmore Hotel, Atlanta, April 3, 4, 5, 1947.

Dr. John D. McArthur, of the University of Georgia School of Medicine, Augusta, and Dr. John McAllister, of the University of Rochester Medical School, Rochester, N. Y., have been added to the staff of the Glynn County Board of Health, Brunswick, and will assist the local public health program, primarily in the VD clinics and in the pre-school health examination clinics where school children are being examined before the opening of school.

Dr. Thomas H. McGuire, Union Point, announces his return from the Medical Corps of the U. S. Navy and the opening of his office for the practice of medicine at Union Point.

Dr. Samuel W. Norwood, Atlanta, announces his return from military service and resumption of the practice of obstetrics and gynecology at 565 Lee Street, S. W., Atlanta.

The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, announces the dates of the 1947 Assembly will be February 24, 25, 26 and 27; headquarters at the Municipal Auditorium, New Orleans.

Dr. Lewis H. Oden, Blackshear physician, has been awarded the Bronze Star by the U. S. Army on the basis of his record as an Army medical officer. A citation came from Army Headquarters in the European Theater, praising Dr. Oden, who was a lieutenant colonel in the Army, for "meritorious service in connection with military operations as Chief, Burns Section, 21st U. S. General Hospital, from Jan. 2, 1943 to May 8, 1945.

"During the campaigns in North Africa, Italy and France," it said, Col. Oden "displayed great energy and ingenuity in suggesting and carrying out new and improved methods for the best interests of his patients.

"His undefatigable devotion to these difficult and painfully injured casualties and his long hours of application made possible the reduction of physical suffering and shortened the hospital disability time, contributing materially to the success of the war effort and reflecting great credit upon him and the armed forces of the United States."

Dr. Lee Parker, a native of Waycross, announces his release from the Medical Corps of the U. S. Navy and the opening of his office for the practice of medicine at Greensboro.

Dr. Thomas Parran, Washington, serving his third term as Surgeon-General of the United States Public Health Service, is reportedly being considered for the post of Director-General of the new World-Health Organization. Dr. Parran was quoted as saying he preferred to "continue to fight for better health in the United States."

Dr. Newdigate M. Owensby, Atlanta, was appointed at the 1946 annual meeting of the American Psychiatric Association as a member of the Committee on Public Education for five years.

The Macon Veterans Administration sub-regional office, Macon, with the arrival of Dr. George F. Carrol, is the first of its kind to have the full-time services of a medical officer. Dr. Carrol, a native of Atlanta, served as a lieutenant colonel in World War I, returning to civilian practice in 1919 at Biloxi, Miss. He remained there until 1935, during which time he was surgery consultant at the Veterans Administration there. In 1935 he entered full time Army service.

Dr. Carrol stated that his office in the VA building, Macon, will be open during regular duty hours. His



work will be to see that men receive proper hospitalization, and are taken care of promptly and efficiently in every way possible.

Dr. Hal M. Davison, Atlanta, was recently elected president-elect of the American College of Allergists at the meeting of the association in San Francisco.

Dr. Rufus Payne, director of the Battey State Hospital, Rome, recently addressed the Rome Kiwanis Club at their weekly luncheon at the Greystone Hotel. Dr. Payne has been connected with the State Board of Health for the past ten and one-half years, and has been in charge of tuberculosis work for the past two years. As director of the new hospital he is enlarging the State's program for the treatment of tuberculosis patients.

Dr. Fincher C. Powell, formerly of Atlanta, recently released from the Medical Corps of the U. S. Navy, is now located in the offices of Dr. W. P. Smith, Church Street, Decatur, for the practice of medicine.

Dr. Robert E. Shiflet, a native of Augusta, announces his return from military service and has opened his office in the Wells-Acree Building, Toccoa, for the practice of internal medicine.

Dr. Harrison H. Shoulders, Nashville, Tenn., took office as president of the American Medical Association at the organization's annual convention at San Francisco. A veteran of World War I, he is a noted surgeon.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, September 5. The meeting was dedicated to Dr. Thomas Dick Longino in celebration of his one-hundredth birthday, September 7. Program: "Myxedema Heart Disease." Case report from Grady Memorial Hospital, Dr. Julian Lentz. Discussion: Dr. R. Bruce Logue; "A Tribute to Our Centenarian," Dr. Frank K. Boland; Paper: "Muscular Relaxation in Abdominal Surgery With Use of Pentothal-Oxygen and Curare." Report of over 600 cases, Dr. T. C. Davison and Dr. A. H. Letton.

Dr. Cyrus H. Stoner, Atlanta, announces the opening of his offices, 1029-30 Candler Building, Atlanta. Practice limited to ophthalmology.

Dr. J. P. Ward, formerly of Greenville, Miss., assumed duties as commissioner of the newly-established Colquitt-Brooks counties health department, disclosed that tentative plans call for 60 per cent of his time being devoted to supervising health operations in Colquitt County and 40 per cent of his time to Brooks County.

Dr. P. L. Williams and Dr. L. E. Williams, Cordele, announce the removal of their offices to the former Browder residence on Thirteenth Avenue, Cordele.

Dr. R. Hugh Wood, Atlanta, has been appointed dean of the Emory University School of Medicine to succeed Dr. Eugene A. Stead, Jr., who recently resigned to accept a position at Duke University, Durham, N. C., Dr. Goodrich S. White, Emory president, announced.

The Seventh Annual Congress on Industrial Health of the American Medical Association, Chicago, will meet at the Copley-Plaza Hotel, Boston, Sept. 30 through Oct. 2, 1946. Program: Monday, Clinical Toxicological Conference, "Lead Poisoning." Surgical Conference, "The Foot in Industry." Professional Relations Conference and Dinner. Tuesday, Opening General Session, Topic, "Human Relations in Industry." Elective Seminars: Section A—"Industrial Physiology." Section B—"Administrative Methods." Section C—"Workmen's Compensation." Dinner and Conference on Pan-American Industrial Health. Wednesday: General Session, "Atomic Energy—Its Effects in Industry and Medicine." "A Positive Health Program for Industry." Dinner and Conference on Health and Welfare Programs in Indus-

try. All requests for hotel rooms should be made through the Copley-Plaza Hotel, Boston.

The University of Georgia School of Medicine, Augusta, through grants of money received from the United States Public Health Service, members of the faculty of the University will be able to carry forward several important research projects, it was recently announced.

Dr. Robert Greenblatt and Dr. Robert Dienst were allocated \$5,550 for study of newer venereal diseases other than syphilis and gonorrhea.

Dr. V. P. Sydenstricker receives \$12,550 for research in internal medicine revolving around the liver.

An award of \$14,375 was made to Dr. Hervey Cleckley for research in psychiatry. A part of the program will deal with electroencephalography through which graphs of the brain can be made in much the same manner that cardiographs are now being made of the heart.

Electroencephalography is comparatively new and Dr. Cleckley's work in that field, under the new grant, will be the first studies of that kind made at the medical school.

Dr. W. D. Willcox and Dr. Francis Ward, both of Fitzgerald, announces the removal of their offices to 216 South Main Street, Fitzgerald. The white frame house was recently renovated into one of the most complete and up-to-date laboratories and convenient offices for the doctors, who returned during the past year from service with the armed forces to resume their practice of medicine in their home town.

Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, Augusta, recently announced bronze plaques memorializing Dr. William J. Young, Fairfax, S. C.; Dr. Flournoy Carter, Augusta; and Mrs. Julia Carter Moore will be placed in the library of the University as soon as bids are awarded and the memorial plaques completed.

Dr. Young left a legacy of \$25,000 to the medical school library when he died in 1920. Mrs. Moore likewise bequeathed \$10,000 to the medical school library in 1926 as a memorial to her father, the late Dr. Flournoy Carter.

The bequest honoring Dr. Carter was used in renovating the library and a similar amount, given by the Rockefeller Foundation, was used to purchase new books. Most of the books now being purchased for the library, Dean Kelly said, are bought with the income from Dr. Young's legacy. The library now has 17,536 books and receives 240 current journals published in English, French, and German.

Although the library is small, compared with those on which millions of dollars have been spent at other schools, it is considered satisfactory, although bequests similar to those already received would make it possible to enlarge the library. Books can be secured on loan from the Library of Congress in Washington on request, however, which augments the school's library facilities.

Bequests such as those made by Dr. Young and Mrs. Moore, Dean Kelly said, are a valuable gift, worthy of memorialization. The plaques will be moved to the new library whenever a new building is added to the campus under plans now being considered.

The Bibb County Medical Society held its regular monthly meeting at Ridley Hall, Macon, September 8. Program: Dr. W. L. Barton in charge.

The Fulton County Medical Society held a barbecue and entertainment at the Druid Hills Golf Club September 19. Approximately 200 members who served in the Armed forces in World War II were honor guests.

The address of welcome was made by the president of the society, Dr. Thos. P. Goodwyn. Music was furnished

by Graham Jackson with his accordion. Dr. Everett bishop sang "On the Road to Mandalay" and "Ol' Man River." The Emory Unit Quartette added to the program. Dr. T. D. Longino, the oldest member, who was 100 years old this month, discussed "Medicine of Eighty Years Ago." Dr. W. S. Goldsmith discussed "Medicine of Fifty Years Ago." Mr. Ralph McGill, editor of the *Atlanta Constitution*, talked on "What the Medical Profession Means to Civilization in Peace and in War." The president-elect, Dr. Hugh Wood, who has recently been made dean of Emory University Medical School, discussed "Medicine and Surgery of Tomorrow." Dr. T. C. Davison was in charge of the program.

#### OBITUARY

*Dr. Walter Edward Brown*, aged 39, Lumpkin physician and surgeon, died at the Cuthbert Hospital July 24, 1946. Dr. Brown was born in Greensboro, son of Judge and Mrs. Joseph P. Brown. He attended the Greensboro schools, received his pre-medical course at Emory University, and graduated in 1930 from the University of Georgia School of Medicine, Augusta. After graduation he was stationed as CC camp physician at Homerville. Upon the entry of the United States in World War II, he was commissioned a captain in the Medical Corps. He served as flight surgeon in the air corps, in the first invasion of American forces in North Africa. On being retired to inactive duty Dr. Brown established offices at Dalton and several months later moved to Lumpkin to practice medicine.

He was a member of the Lions Club, of the Masonic fraternity, the American Legion, the Whitfield County Medical Society, the Medical Association of Georgia, and a fellow of the American Medical Association. He is survived by his wife, the former Mrs. Ethel Butler Moore; two children, Sara Frances and Hugh Pearce Brown; his parents, Judge and Mrs. Joseph P. Brown, a brother, Edward Brown, all of Greensboro. Funeral services were conducted at the graveside by his pastor, Rev. E. A. Kilgore, of the Greensboro Baptist Church, assisted by Rev. W. N. Bashaw, pastor of the Presbyterian Church of Greensboro. Burial was in the City Cemetery, Greensboro.

*Dr. Benjamin Hill Copeland*, aged 79, prominent Harris County physician, died at his Shiloh home July 18, 1946. Dr. Copeland graduated from the Atlanta College of Physicians and Surgeons in 1900, and began the practice of medicine at Shiloh. He was a member of the A. C. Wether-Harris Medical Society, the Medical Association of Georgia, and a fellow in the American Medical Association. Surviving him are a sister, Mrs. H. D. Dunn, Cuthbert; and a brother, J. T. Copeland, Shiloh. Funeral services were held at the Shiloh Baptist Church with the Rev. Alex Copeland of Hamilton officiating. Burial was in the Shiloh Cemetery.

*Dr. James Felton Covington*, aged 70, Monroe and East Point physician, died at his home 614 Jefferson Avenue, East Point, August 21, 1946. He was a native of Cherokee County, and graduated from the Hospital Medical College, Eclectic, Atlanta, in 1911. Dr. Covington took his postgraduate work at the College of Physicians and Surgeons, New York, and more work at Duke University Hospital, Durham, N. C., and the Mayo Clinic, Rochester, Minn. He was a member of the Walton County Medical Society, the Medical Association of Georgia, and a fellow of the American Medical Association. He was a Mason, and a member of the First Baptist Church, East Point. Survivors include his wife, the former Annie Hawkins of Cumming; four daughters, Misses Obriene and Erliene Covington, both of East Point, Miss Geraldine Covington and Mrs. H. C. Yarbrough, both of Birmingham; a son, J. F. Covington,

Jr., Atlanta; a sister, Mrs. Emma Massey, Birmingham, a brother, Gordon Covington, Ball Ground; and a grandson, H. C. Yarbrough, Jr., Birmingham. Funeral services were held at Spring Hill, Atlanta, with Rev. Paul A. Meigs, officiating, assisted by Dr. Robert W. Burns. Burial was in Crest Lawn Cemetery, Atlanta.

*Dr. Joseph Harper Gaston*, aged 46, Columbus bone specialist, was found dead in his office at 1308 Third Avenue, Columbus, July 14, 1946. A coroner's jury returned a verdict of death due to a heart attack. He graduated from Emory University School of Medicine, Atlanta, in 1923. Dr. Gaston was a member of the Muscogee County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association. Surviving are his widow, Mrs. Louise Hays Gaston; a son, Joseph Harper Gaston IV, both of Columbus; a sister, Miss Doris Gaston, and a brother, Leverett Gaston, both of Greenville. Funeral services were held at the Greenville Presbyterian Church. The Muscogee County Medical Society served as an honorary escort. Burial was in Greenville Cemetery, Greenville.

*Dr. Goodwin Gheesling*, aged 57, beloved physician and surgeon of Greensboro, died June 22, 1946. Dr. Gheesling died suddenly at Great Wood Lake, Manitoba, Canada, where he and his wife, accompanied by Mr. and Mrs. Cleo Archer, of Sandersville, were on a fishing trip. He was the only son of the late Dr. J. H. Gheesling and Mrs. Emma Goodwin Gheesling, life long citizens of Greensboro. He graduated from the Atlanta College of Physicians and Surgeons in 1912. Following his internship at Grady Hospital, Atlanta, he returned to Greensboro to practice medicine with his beloved father. He was a member of the Greene County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association, and a life long member of the Greensboro Baptist Church. He is survived by his wife, a daughter by a former marriage, Miss Hilma Gheesling, who is doing Red Cross work in Germany; three sisters, Mrs. C. C. Davison, and Mrs. Hamp McGibony, both of Greensboro; and Mrs. Reuben Tuck, Covington. Funeral services were held at the residence with the Rev. E. A. Kilgore officiating, assisted by the Rev. Charles H. Kopp, of Montezuma. Burial was in the City Cemetery, Greensboro.

*Dr. Oliver Doyle Hall*, aged 69, prominent Atlanta surgeon, of 545 East Ponce de Leon Avenue, Decatur, died Aug. 13, 1946 in a private hospital, after a short illness. He was born in Franklin County, received his preliminary education at Young Harris College and was graduated from the Atlanta College of Physicians and Surgeons in 1906. He also attended the Baltimore Medical College. Dr. Hall had a general practice in Buford for about ten years, and came to Atlanta in 1916 to begin a career that led him to prominence in the cancer field. During his years of practice he specialized in radium therapy and in 1931 made a gift of radium valued at \$11,000 to the Georgia Baptist Hospital with the idea of establishing a cancer clinic. Mr. I. M. Sheffield of Atlanta, made a donation that resulted in the establishment of the clinic, which was dedicated on Oct. 6, 1939. Dr. Hall was resident director of the Sheffield Clinic which he helped to found. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, was a fellow of the American Medical Association, and a member of the First Methodist Church, Decatur. He is survived by his wife, the former Mary Estelle Medlock of Norcross; two daughters, Mrs. T. A. Seals, Macon, and Mrs. W. D. Cornell, Atlanta; a son, O. D. Hall, Jr., Atlanta; three brothers, the Rev. John L. Hall, Stone Mountain; Rev. C. A. Hall, Atlanta; and Ernest F. Hall, Waverly Hall; and four grandchildren. Funeral services were held at



Spring Hill, Atlanta, with the Rev. George M. Acree and Dr. Wallace Rogers officiating. Burial was in the Decatur Cemetery, Decatur.

Dr. Richard Emmett Newberry, aged 50, prominent Atlanta physician and surgeon, died at his home 2160 Ponce de Leon Avenue, Atlanta, after a short illness, Aug. 12, 1946. Born in Jakin, the son of the late Mr. and Mrs. G. R. Newberry, he attended Mercer University and later graduated from Emory University School of Medicine, Atlanta, in 1921. He was a member of the Atlanta Kiwanis Club, the Druid Hills Men's Garden Club, the Shrine and the Glenn Memorial Methodist Church. Prominent in medical circles, he was a member of the Fulton County Medical Society, the Medical Association of Georgia, the Southeastern Surgical Congress, was a fellow in the American Association of Industrial Surgeons and Physicians, and a fellow of the American Medical Association. He was a member of the Theta Kappa Psi medical fraternity, and had served on the staffs of St. Joseph's, Crawford W. Long and Georgia Baptist hospitals. Survivors include his wife, the former Miss Mary Durham Sloan of Anderson, S. C.; one daughter, Miss Vivian Newberry; a brother, Gordon E. Newberry, Waverly Hall; and five sisters, Mrs. R. L. Barbee, Blakely; Mrs. C. D. Murphy and Mrs. Neal Clark, Decatur; Mrs. C. M. Hobbs and Miss Beatrice Newberry of Atlanta. Funeral services were held at the home, 2160 Ponce de Leon Avenue, Atlanta, with Dr. Fred R. Chenault and Dr. E. J. Mackay officiating. Burial was in West View Abbey, Atlanta.

Dr. Adrain Dallas Williams, aged 67, Folkston, died at St. Vincent Hospital, Jacksonville, Fla., after a brief illness, Aug. 3, 1946. Dr. Williams was born at Brunson, S. C., the son of the late Dr. A. D. Williams and Belle H. Williams. He received his early education in local schools and The Citadel at Charleston, and completed his medical education at the Medical College of the State of South Carolina, Charleston, in 1904. He was a veteran of World War I, serving with the famous Fifth Division as medical officer with the rank of major. Dr. Williams was a practicing physician and surgeon at Folkston since 1908. He was a member of the Masonic Lodge of Folkston and the Waycross Lodge of the American Legion Post, and took an active part in welfare work. He is survived by his widow, Mrs. Myra Mizelle Williams; one daughter, Mrs. M. D. Hiers, Jacksonville; a son, Eugene M. Williams, Baldwin, two grandchildren, and two sisters, Mrs. Kenneth Ranson, Detroit, Mich., and Mrs. J. C. McCall, Charlotte, N. C. Funeral services were held at the home. Burial was in the Folkston Cemetery.

#### RESEARCH FOR EMORY

A grant of \$12,500 from the U. S. Public Health Service for fundamental research in the mechanics and effects of fever by two Emory University professors has been announced by Dr. R. Hugh Wood, dean of the Emory School of Medicine.

The research, which began July 1, is being carried on by Dr. Paul B. Beeson, professor of medicine, and Dr. Albert Heyman, instructor in medicine and director of the Venereal Disease Clinic at Grady Hospital, in Atlanta.

The two men have worked as a team for the past three years on research projects, under similar grants from the Public Health Service, but this is the first year in which they have turned their efforts on the problem of fever. Previously their research has been on various phases of venereal diseases, particularly penicillin treatment of syphilis.

Dr. Beeson is a graduate of the McGill University School of Medicine, in the class of 1933. Dr. Heyman holds an M.D. degree from the University of Maryland, awarded in 1940.

#### LIMITED SUPPLY OF BOUND VOLUMES 1, 2 AND 3 OF THE QUARTERLY REVIEW OF OBSTETRICS AND GYNECOLOGY NOW AVAILABLE

During the past two years, and particularly the past few months, there has been an increasing demand for Volume 1, 1943, Volume 2, 1944 and Volume 3, 1945, of the *quarterly review of obstetrics and gynecology*.

The shortage of paper and other supplies as well as the greatly increased printing costs prevents us from reprinting a supply to meet all demands as this cannot be done profitably. In an effort to cooperate with those who desire complete volumes, we are now reprinting 1,000 sets of these in permanent bound volumes. These are available at the original price of \$25.00 for the set, resulting in our accepting a loss on each set sold.

More than 400 of these sets have been sold and orders will be filled in the sequence received until this supply is exhausted. The three volumes contain 2,193 pages (6 $\frac{3}{4}$  x 10) presenting 3,663 abstracts of obstetrical and gynecological papers of importance, representing the work of more than 2,000 clinicians, research workers, teachers and bibliographers.

Those desiring complete volumes should communicate immediately with the Washington Institute of Medicine, 1720 M Street, N. W., Washington 6, D. C.

#### LEVULOSE AVAILABLE

Levulose, the simple sugar of high sweetness, will now be available for the first time in sufficient quantities for experimental work by physicians, physiologists, biochemists and others, Dr. Carl W. Borgmann of the Engineering Experiment Station at the University of Colorado announced recently.

The pilot plant, which has been in production for some time, uses an ion exchange process to obtain levulose from common sugar and represents the only commercially feasible method in actual operation. Satisfactory yields of levulose have also been obtained from beet molasses, Dr. Borgmann reported.

"Although levulose, often referred to as fructose or fruit sugar, is an important natural sugar with many potential uses in food industries, there has never been enough of it for extensive study because of the high cost and difficulty of separating it by traditional methods. The pilot plant method is relatively simple and cheap. Another advantage of this process is that it achieves a true separation without destroying the dextrose fraction," Dr. Borgmann said.

"The Jerusalem artichoke, goldenrod, chicory, and dahlias all contain inulin, a substance which can be treated to obtain levulose, but common sugar seems to be the most promising source," he added.

The pilot plant, operated on a grant from the Sugar Research Foundation, is currently producing enough levulose to supply laboratories and research projects. Studies are also being made to estimate costs and technical problems involved in actual manufacture on a large scale.

In addition to its high sweetness, levulose has a higher solubility than either sugar or dextrose. Recent research also suggests that it may have unique and important physiological effects. Lack of availability in the past has hindered research, but studies are now being carried out at the Michael Reese Hospital in Chicago to find out more about the storage of levulose in the body, its use by various organs and its effect on blood lactic acid.

It is known that levulose is absorbed and stored by the liver at two and a half times the rate of dextrose. In the liver it is transformed into glycogen (animal starch) and, as such, provides readily available blood sugar reserves. Glycogen also appears to have a protective action possibly preventing cirrhosis and guarding the liver against toxic agents.

Levulose also evidently plays an important but unknown role in early life. English researchers have recently discovered that ninety per cent of the blood sugar of embryonic lambs consisted of levulose.

In human metabolism common sugar breaks down into forms of its component parts. Recent disclosures suggest that sugar may actually be split directly to dextrose phosphate and levulose. The rate of absorption of levulose is being studied by Dr. I. M. Rabinowitch of Montreal General Hospital, who has recently shown the value of higher carbohydrate diets for diabetics. In this connection, levulose may prove particularly valuable.

More knowledge about the function of levulose in human nutrition will be forthcoming from the tracer or "tagged" atom technique. By building levulose with atoms of radioactive Carbon 14, it will be possible to follow the course of this sugar through various body organs, and learn more about its deposition and utilization.

#### U. S. P. XIII IN SPANISH

The Board of Trustees of the United States Pharmacopoeial Convention has authorized the translation of the coming U.S.P. XIII into Spanish, and Dr. A. A. Moll, Assistant Director of the Pan American Sanitary Bureau, will again undertake the translation. Dr. Moll also supervised the translation of both the U.S.P. XI and XII.

United States Pharmacopoeial standards have been widely adopted in Central and South American Republics and the U.S.P. has also been looked upon favorably by the Spanish pharmacopoeial commission in Madrid. The demand for the Spanish edition has practically doubled in the past several years, indicating again the closer relationships which are being developed throughout the Americas.

The Spanish edition has been legally adopted as the official Pharmacopoeia in Costa Rica, Cuba, Dominican Republic, Nicaragua, Panama, Puerto Rico, and the Philippines. It has been strongly recommended and is being considered for adoption by several other countries.

#### DENTAL CARE FOR VETERANS

Veterans with service-connected dental conditions now may have a "free choice" of private dentists when Veterans Administration dental clinic service is not "feasibly available," VA announced Aug. 27, 1946.

Under a new fee-schedule program, worked out in cooperation with the American Dental Association, VA will pay the bills for this service given by local "participating dentists on a fee basis," as they are called, when the veterans cannot be taken care of in VA's own dental clinics.

The new program also revises previous fee schedules, which became antiquated because they did not reflect rising costs. This makes it possible for more dentists to help treat eligible veterans. The new fee schedule is now in effect and operating.

The program makes it possible for a veteran with a service-connected dental condition to receive home town care such as the eligible veteran with a service-connected medical disability receives when he goes to a physician. The dental program covers the entire country while medical contracts to date include 12 states with approximately 20 other state-wide contracts under negotiation.

A directive on the VA dental care program said in part:

"It is the approved policy of VA to appoint, on a fee basis, all ethically and professionally qualified dentists who wish to render dental service to veterans. Dentists should be nominated by the State Dental Society and their appointments are subject to the approval of the Chief, Dental Division, Branch Office."

Deviations from the national fee schedule are permitted at the state level when approved by VA branch representatives, if necessary to meet the fees usually charged the general public for similar services.

Each state dental society has been requested to name a dental advisory committee to approve nominations of applicants and to make recommendations for any adjustment of fees at the state level. Appointments are actually made by the VA branch office through letters of appointment issued by the branch office's director of personnel service.



**SCIENCE AT THE NATION'S PLAYGROUND** — a top scientific medical meeting amid delightful tropical surroundings with every known recreational facility available — Southern Medical Association, Miami, November 4-7. The Southern Medical Association meetings always have been and always will be the **ESSENTIAL** medical meetings **IN** and **FOR** the South. In its twenty-one scientific sections, the four general clinical sessions, the general public session, the four conjoint meetings and the scientific and technical exhibits, in a streamlined program, one will get the last word in modern, practical, scientific medicine and surgery. And after Miami, Havana and/or Nassau.

**REGARDLESS** of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Miami a scientific program and recreational facilities to challenge his every interest and make it worth-while for him to attend.

**ALL MEMBERS** of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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### CONGENITAL CARDIOVASCULAR MALFORMATIONS

#### *Discussion of Some of the More Common Types*

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WM. WILLIS ANDERSON, M.D.  
*Atlanta*

For many years congenital heart disease has been a subject of great interest to practitioners of medicine. The prominence of physical signs of many of the congenital cardiac defects has of necessity focused considerable attention on them, and the wide differences in prognosis with regard to the various lesions made it extremely important to differentiate them not only from one another but also from acquired heart disease.

The importance of accurate diagnosis of congenital malformations of the heart and great vessels has been greatly increased during the past few years by the development of surgical procedures that correct or modify some of the more common of these abnormalities. Also the discovery of a curative therapy for a large percentage of cases of subacute bacterial endocarditis, a disease which formerly caused the premature death of many persons with congenital cardiovascular defects, has increased the total number of living persons with these malformations, and hence the number seeking medical advice.

An effort will be made in this paper to present briefly and concisely the pertinent diagnostic features of the commoner types of congenital cardiovascular lesions.

It is of great help in distinguishing one type of congenital cardiovascular disease from another, and from acquired heart disease, to have<sup>1</sup> (1) a mental list of the anatomic possibilities and (2) a mental picture of how each lesion modifies or burdens the physiologic mechanism and thus produces the distinctive physical signs. Following the classification of Maude Abbott<sup>2</sup> it has become customary for clinicians to divide the congenital cardiovascular lesions into the acyanotic, the delayed or potentially cyanotic and the cyanotic groups.

#### *Acyanotic Group*

The distinctive clinical feature of this group is that there is no abnormal communication between the pulmonic and systemic circulations, and hence no possibility of a venous-arterial shunt.

Anomalies of the aorta are among the more common of the malformations of this group.

*Coarctation of the aorta.* Two types are described:

a. Infantile type with a diffuse narrowing of the portion of the aorta beginning just distal to the origin of the left subclavian artery and extending to a point just proximal to the insertion of the obliterated ductus arteriosus. This narrowing may be of minimal degree and produce no clinical signs or symptoms or may be more severe and present the characteristic features of the so-called adult form of coarctation.

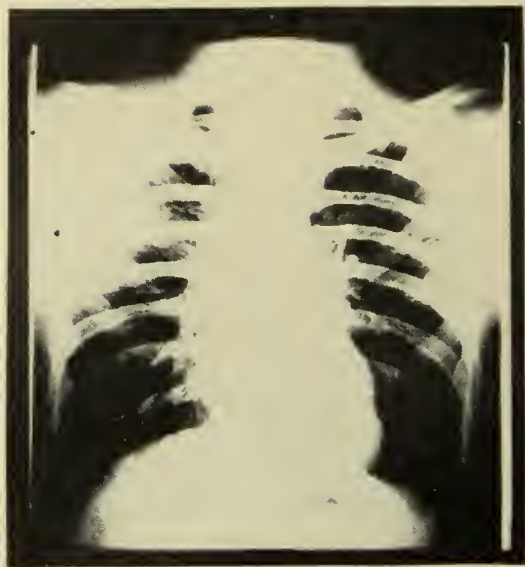


Figure 1

Erosion or scalloping of under surface of ribs in coarctation of the aorta.

b. In the adult type there is abrupt narrowing or obliteration of the aorta usually at a point just above the union of the ductus arteriosus (usually obliterated). There thus results a high pressure in the part of the aorta and its collaterals above the constricted area and a lower pressure in the aorta and collaterals below it. The outstanding features of this anomaly are represented by the following case study:

A 19 year old boy was sent in for study because of hypertension. He had no complaints whatever. First found that he had high blood pressure one year before when he applied for a job as an inspector in a steel plant—was told then pressure was 180. Enlisted for the Navy and was rejected because of hypertension. Was drafted by the Army and similarly rejected.

Always very healthy in his own opinion. Played baseball and basketball and swam extensively. Had no cardiac symptoms except for awareness of heart action at times.

He was a very well developed, robust young man. Positive findings were limited to the cardiovascular system. Tortuous arteries were palpable in the lower cervical triangles of the neck, and vigorous pulsations were felt in these vessels, as well as in the infraclavicular, interscapular and infra-axillary regions. Over these areas a mid-systolic murmur was audible of a quality and intensity simulating that of the uterine bruit late in pregnancy.

The heart was of normal size. The apex impulse was rather forceful and the aortic second sound was accentuated. The femoral and popliteal pulses were just palpable, the dorsalis pedis barely perceptible and the posterior tibial pulsation could not be felt. B.P., right arm 175/110, left arm 160/110; right arm 190/115, left arm 185/115 (just after blood count), in the right leg 115, left leg 110 (by palpation of the dorsalis pedis pulses).

EKG was normal in this patient but frequently shows some left axis deviation.

X-ray of chest (Fig. 1) showed characteristic erosion or notching of the under surface of many of the ribs.

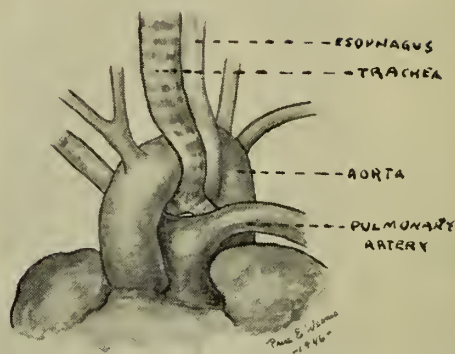


Figure 2

Sketch from a case of right aortic arch with a left descending aorta. Note the second portion of the aortic arch posterior to the esophagus and trachea.

The cardiac silhouette was not enlarged. The aortic knob was not prominent.

**Prognosis.** The average age at death of patients with coarctation in Abbott's series was 36 years. One attained the age of 92 years despite an extreme degree of stenosis. Common terminal events are cerebral vascular accidents, rupture of the arch of the aorta and superimposed subacute bacterial endocarditis.

The early recognition of this congenital defect has become of great practical importance since Gross,<sup>3</sup> of Boston, and independently Crafoord and Nylin,<sup>4</sup> of Sweden, devised a surgical technic for its correction. This procedure involves the resection of the area of coarctation and reanastomosis of the divided ends of the aorta.

**Anomalies of the aortic arch.** There are several types of such malformations, some of them causing no signs nor symptoms and are of no clinical significance; e.g., persistent right aortic arch with a right descending aorta. Among the most common of the anomalies producing a classical clinical picture is that of a right aortic arch and a left descending aorta (Fig. 2). In such a case the aortic arch lies posterior to the esophagus and trachea, usually at about the level of the bifurcation of the trachea. Infants with such an anomaly have considerable trouble. Common symptoms are: stri-





Figure 3

Lateral view with barium swallow from a case of right aortic arch with left descending aorta. The esophagus is angulated sharply forward at the point where the aorta passes behind it.

dor, brassy cough, dyspnea, dysphagia and recurrent attacks of bronchitis and bronchiolitis. As the child grows and the trachea becomes larger, they seem to adjust to the condition and usually throughout childhood and adult life are asymptomatic unless they acquire subsequent disease of the aorta.

This condition can be diagnosed with certainty by the simple procedure of fluoroscopy with a barium swallow. In the lateral view the barium filled esophagus can be seen to be angulated sharply forward by the aorta as it passes behind it (Fig. 3). The pulsation of the aorta behind the esophagus is easily distinguished.

In the anteroposterior view there is seen a prominence of the great vessel shadows on the right and their absence on the left. A filling defect is usually noted in the esophagus at the level of the 4th and 5th thoracic

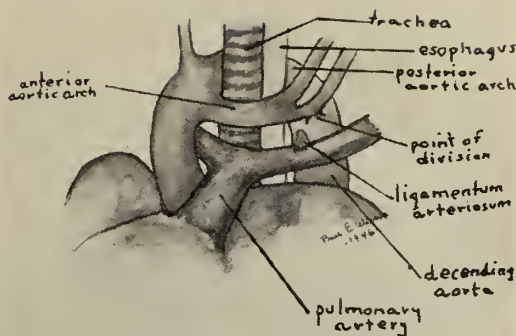


Figure 4

Diagrammatic sketch from a case in which there was persistence of both the right and left aortic arches, forming a constricting vascular ring around the trachea.

vertebrae. The esophagus is displaced slightly to the left. The heart is normal in size in uncomplicated cases.

A similar but usually more severe set of symptoms are produced by the presence of a vascular ring enclosing the trachea and esophagus. This is usually the result of the persistence of both the right and left aortic arches, either both or full caliber or with suppression or obliteration of part of the arch.

Figure 4 is a diagrammatic sketch of such a malformation seen in an eleven month old baby with a history of noisy breathing since birth, and recurrent, severe, respiratory infections necessitating four lengthy hospitalizations. Physical examination was negative except for slight undernutrition, stridor and dyspnea.

A diagnosis of right aortic arch with left descending aorta was made by fluoroscopy in lateral view following a barium swallow. But the findings in this child differed from those in a simple persistent right aortic arch with left descending aorta in that (1) In the AP view the esophagus was in midline and (2) by lipiodol bronchogram there was demonstrated concentric constriction of the trachea at the same level of anterior angulation of the esophagus. It was therefore concluded that the child had a constricting vascular ring. She was explored by Dr. Robert Gross, Boston.<sup>5</sup> The small left arch of the aorta was ligated and divided as shown in the sketch. Following this procedure her difficulties were greatly decreased, but a moderate degree of stridor persisted.

#### *Potentially Cyanotic Group*

This group includes those malformations in which, while there is abnormal communication between the systemic and pulmonic circulations, cyanosis is not ordinarily present. This is due to the fact that the pressure in the systemic circulation is normally higher than in the pulmonic and the shunt is



Figure 5  
Teleoroentgenogram from a case of patent ductus arteriosus in an 11-year-old girl prior to operation.



Figure 6  
Teleoroentgenogram of same patient as Figure 5 nine days after the ductus was operated on uneventfully.

from the former to the latter; i.e., arterial to venous. However, shunt reversal is possible if for any reason there occurs elevation of the pulmonic pressure above the systemic. Since such a reversal of shunt usually develops late in life with heart failure, often as a terminal event, the term "late cyanotic" (cyanose tardive) is applied to this group.

*Patent ductus arteriosus.* One of the most common of the types of congenital cardiovascular malformations belonging to this group is that of patent ductus arteriosus. The correct diagnosis of this lesion is of utmost importance because it too has been definitely placed among the forms of curable heart disease. While this congenital lesion is usually asymptomatic in early life, the total life expectancy in untreated cases is less than for the general population. The open ductus is a frequent site of bacterial endocarditis and the advent of cardiac enlargement and failure is of relatively common occurrence.

The physical findings are usually suffi-

ciently distinctive to be diagnostic. The classical murmur of patent ductus is frequently described as a humming top or machinery murmur or as similar to the sound produced by a train roaring through a tunnel. This murmur begins after the first sound and is continuous throughout the greater part of the cardiac cycle. It is usually best heard below the left clavicle in the first, second and third intercostal spaces, frequently maximal in the second. A continuous thrill is usually palpable over this area. The systolic component of the murmur in most cases is audible all over the precordium, in the axilla, over the great vessels in the neck and often high in the interscapular region. In infants and young children with a patent ductus, ordinarily only a systolic murmur is audible, a continuous murmur being rare. The systolic blood pressure is usually normal and the diastolic pressure somewhat low. A pulse of Corrigan or collapsing character is frequent. The EKG is often normal but may show right axis deviation. X-ray examina-





Figure 7  
Teleoroentgenogram of a case of interauricular septal defect in which there was tremendous enlargement of the pulmonary artery.

tion is helpful in the diagnosis of this condition. Roentgen signs to be looked for are:<sup>6</sup>

1. Enlargement of pulmonary artery.
2. Engorgement of pulmonary vessels.
3. Enlarged left ventricle.
4. Enlarged left auricle.
5. Exaggerated beat of the left ventricle and pulmonary artery.
6. "Hilar dance" systolic expansion of the large vessels in the hila of the lungs.

All of these findings are rarely seen in any individual case, but one or several of them are usually demonstrable.

Figure 5 is a reproduction of a teleoroentgenogram of an 11 year old girl. At the age of 8 years she was discovered, on a routine camp examination, to have a loud continuous murmur maximal in the left infraclavicular area. She had been completely asymptomatic except for some difficulty in keeping up with children her own age in more vigorous sports. The x-ray showed moderate enlargement of the pulmonary conus and some engorgement of the vascular trunks throughout both lung fields.

Figure 6 shows a teleoroentgenogram on the same patient 9 days after the ductus was operated on uneventfully, and shows the pulmonary conus now within normal limits and the pulmonary vessels less engorged than previously.

The first successful ligation of a patent ductus was performed by Gross of Boston in 1938.<sup>7</sup> Since that time it has been performed in numerous cases in nearly every sizable medical center. The results in general have been excellent and the mortality



Figure 8  
Characteristic roentgenographic appearance in interauricular septal defect, with massive right-sided cardiac enlargement and only moderate enlargement of the pulmonary artery.

rate strikingly low. The present procedure involves division of the ductus after double ligation where length of this structure permits. As regards indication for operation, it is the opinion of many experts in the field of congenital heart disease that all patients should be operated on unless there is some individual contraindication.

*Interauricular septal defects.* Patency of the foramen ovale is one of the most common of all congenital cardiac abnormalities. In the great majority of cases the defect is small and produces neither sign nor symptom of heart disease. However, a widely patent foramen ovale or other gross defect in the interauricular septum results in a distinctive and incapacitating clinical picture. Because of the large volume of blood shunted from the left auricle to the right side of the heart the right auricle and ventricle may become enormously dilated and hypertrophied and the pulmonary artery considerably enlarged. There are several cases on record in which the pulmonary artery was so dilated that it compressed the left recurrent laryngeal nerve, producing paralysis

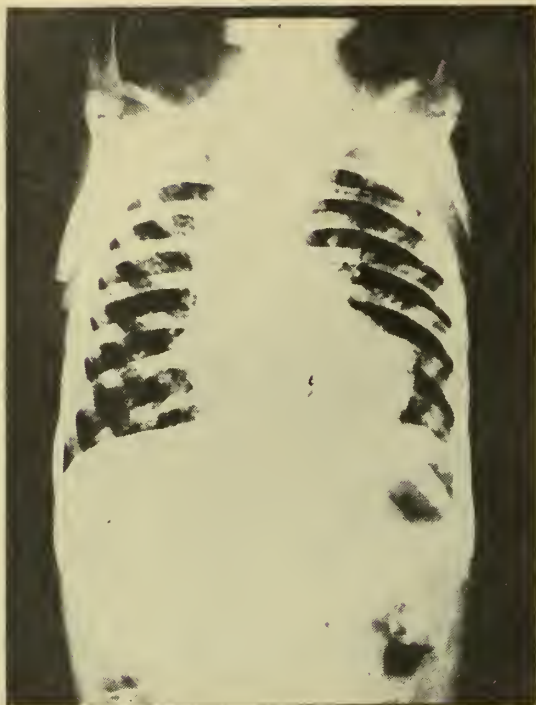


Figure 9  
Teleoroentgenogram of a case of tetralogy of Fallot. Note the characteristic "boot-shape" of the cardiac contour.

of the vocal cord.<sup>8</sup> The aorta, because of the diminished amount of blood it carries, is usually somewhat smaller than normal. Occasionally the systemic circulation is "starved" and the patient shows the so-called "gracile habitus"; i.e., slender, frail build, characteristic of hypoplasia of the aorta. Slight cyanosis may occur on exertion but significant cyanosis appears only in the advent of cardiac failure; clubbing is absent.

Physical examination reveals the great cardiac enlargement, both to the right and to the left of the sternum with the apex impulse displaced downward and outward. There is a pronounced systolic murmur and thrill over the base of the heart in the second and third intercostal spaces. This murmur is usually harsh and occasionally a diastolic component is present. The pulmonic second sound is accentuated.

The roentgenographic appearance of the heart varies with the degree of dilatation of the pulmonary artery. Figure 7 is from a

case in which there was tremendous pulmonary artery enlargement and shows the huge pulmonary arc above on the left.

A more globular contour, as illustrated by Figure 8, is seen in the presence of massive right-sided cardiac enlargement with only moderate enlargement of the pulmonary artery.

The EKG shows right axis deviation, which may be of moderate to marked degree.

*Prognosis.* These individuals are unusually susceptible to rheumatic infection and especially to endocarditis in the region of the defect. In the average case of auricular septal defect the life span is somewhat less than half that of a normal person.

*Interventricular septal defect.* In 1879 Henri Roger<sup>9</sup> first described the clinical picture associated with a defect in the I-V septum. The size of the defect varies but it is usually small, less than 0.7 cm. according to Taussig,<sup>10</sup> and is generally located at the upper part of the septum.

In the great majority of cases the condition is asymptomatic and the patient is discovered on routine physical examination to have a harsh systolic murmur audible over the precordium and maximal in the third left intercostal space adjacent to the sternum. A systolic thrill is usually palpable in this area. The heart is only slightly if at all enlarged.

The cardiac contour is usually normal, as is the EKG. This defect ordinarily causes no disability and does not necessitate restriction of the patient's activity. The prognosis is excellent except for the danger of the development of acute or subacute bacterial endocarditis. Abbott gives the average age at death as 42 years and the maximum 79 years in uncomplicated septal defect.

#### *Cyanotic Group*

In this group there is a persistent shunt



from the venous to the arterial side and hence constant cyanosis and clubbing of the fingers and toes.

The *tetralogy of Fallot* is the commonest malformation of the cyanotic group that is compatible with relative longevity. The four cardinal features composing the tetralogy are:

1. Stenosis of the pulmonary artery.
2. Interventricular septal defect.
3. Large aorta which overrides the defect in the ventricular septum.
4. Hypertrophy of the right ventricle.

When the ventricles contract part of the venous blood in the right ventricle passes out through the narrowed pulmonary artery, but a considerable amount of it along with the arterial blood in the left ventricle goes out via the large dextroposed aorta. The combined effects of this venous-arterial shunt, and the much restricted pulmonary circulation, results in persistent cyanosis and pronounced clubbing of the extremities. The cyanosis begins early in life and often becomes extreme.

Examination of the heart reveals little or no enlargement. There is usually a basal systolic murmur and thrill, but if the polycythemia which accompanies the cyanosis is marked (hemoglobin exceeding 120-125 per cent) no murmur may be heard.<sup>11</sup>

X-ray examination shows the heart to be sabot-shaped because of the prominent right ventricle without enlargement of the pulmonary artery, and because of the dextro-position of the aorta the great vessel shadow will be prominent on the right (Fig. 9).

The EKG usually shows a right axis deviation, evidence of right ventricular strain.

The outlook for these patients has been rather poor. Many of them died young, but the majority attained early adult life. An exceptional patient of White and Sprague<sup>12</sup> lived to the age of 59 years. Their activity is considerably restricted, often markedly

so, by the lack of oxygen in their tissues.

Recently a procedure has been devised and a technic perfected by Blalock and Taussig<sup>13</sup> of Johns Hopkins, Baltimore, in which a major artery (innominate, common carotid, or subclavian) is anastomosed to the pulmonary artery, thus creating a large artificial ductus. This results in a marked increase in the flow of blood through the lungs and thereby reduces the tissue anoxia. This procedure has been carried out only in patients with a severe degree of anoxemia. Clinical evidence of improvement has been striking and includes decrease in intensity of cyanosis and in dyspnea and an increase in tolerance to exercise. The ultimate prognosis of patients following the Blalock-Taussig operation remains to be determined, but if it grants only a few months to a few years of relatively comfortable existence to otherwise incapacitated individuals it would seem to be abundantly worthwhile.

### Summary

The poignant diagnostic features of some of the commoner types of congenital cardiovascular lesions have been presented. Accurate diagnosis, while always important, has become increasingly more so with the advent of surgical procedures which correct or modify many of these abnormalities.

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## DISCUSSION OF PAPER OF DR. LAURA LIPSCOMB

DR. H. C. ATKINSON (Macon): I know of nothing more heartening in medicine than development of a mode of treatment for conditions which have heretofore been untreatable. A monograph which was published only a few years ago on the study of congenital heart disease had on its fly leaf, "A study of 109 cases, 106 with autopsy." It is certainly to be hoped that in the future students of this condition will have a less satisfactory follow-up on their cases.

With the development of surgical treatment for congenital heart disease, the responsibility for the proper evaluation and diagnosis of these cases is greatly increased and the question is coming up about operations in a number of these cases in which, for various reasons, operations should not be done.

Not very long ago a woman who has made out pretty well for about 65 years with a congenital pulmonary lesion was asking my advice about having it operated on and I recommended that she not have it operated on at this time, but that we watch it another 65 years and discuss it again.

We have been given an excellent presentation of the subject under discussion.

DR. L. MINOR BLACKFORD (Atlanta): Congenital heart disease has been of very great interest to me since I prepared a thesis on coarctation of the aorta 20 years ago.

In 1932 Dr. T. F. Davenport and I reported a case of right aortic arch diagnosed in life. This was the first reported case so diagnosed in the English speaking countries, the tenth in the history of the world. Right aortic arch is an interesting anomaly, in itself usually of no clinical importance. It may be associated with other graver defects and sometimes vestiges of other embryonic structures persist to cause dysphagia. Theoretically an unrecognized right aortic arch might complicate bronchoscopy or esophagoscopy.

Dr. Atkinson has stolen my thunder because I had wanted to remonstrate against the dictum that, as soon as you make a diagnosis of one of the four types of lesions that can be corrected by surgery, it is necessary at that time to operate. We do not have enough published routine autopsies to justify that position. When a person dies of complications of a patent ductus, it's apt to get into the literature, but we don't know how many thousands of people with patent ductus die at a ripe old age of unrelated causes.

If I may revert to the case of right aortic arch reported by Dr. Davenport and me, this boy also presented a patent ductus arteriosus, with atresia of the pulmonary artery, and yet he lived to the age of 22, dying of meningitis with meningococcemia. The heart valves were not involved.

Coarctation of the aorta also requires more detailed studies. When a robust young athlete falls dead from a rupture of the aorta or of a cerebral aneurysm, it is a dramatic event which is apt to be reported. A surgical correction of the coarctation will not correct the congenital intracranial aneurysms often associated, though it is admitted that it will tend to diminish the pressure and therefore lessen the susceptibility to rupture. Successful operation, with the new intraluminal suture line, will not obviate the possibility of subacute bacterial endocarditis and theoretically should rather increase the chances of an endarteritis. Certainly Dr. Atkinson's lady of 65 did not need an operation.

The Taussig-Blalock procedures for the correction of cyanosis are most promising and they have enabled a number of children crippled with heart disease to lead a fairly normal life.

It is admitted that these anomalies are subject to certain dangers and surgical correction of the anomalies will forestall the dangers. On the other hand, every infant born with an appendix may develop acute appendicitis which may not be recognized before the organ ruptures. To operate routinely on all operable cardiac anomalies seems to me as logical and as intelligent as to remove the appendix routinely.

When you make the diagnosis of congenital heart disease, let me urge you to consider carefully before you submit the patient to operation. Incidentally, there are at least two surgeons in Georgia, one in Atlanta and one in Augusta, who are capable at this time of doing these operations, so if you have a case of congenital heart disease that needs operation remember that you can have it done at home.

DR. THOMAS ROSS (Macon): I would like to make just one statement about the part of the paper that we were able to hear; that is, particularly in cases of coarctation of the aorta the cardinal symptoms described to us are not always present. I was privileged to do cardiac work for the past four years in the Army and a good many of these cases were picked up by simply being aware that congenital cardiac disease does exist. Coarctation of the aorta was sometimes discovered by palpation of the femoral arteries. It is very nice when you get erosion of the ribs and all of the murmurs that are supposed to go with coarctation, but sometimes the coarctation is not severe enough to give us enough tortuosity of the vessels to give erosion of the ribs. We had about 30 cases in the four years and in every one we got at least diminution of pulsation of the femoral vessels, and in a good many complete absence of pulsation. It is very easy when you have a young adult with hypertension to simply put your hands around his hips and your thumbs will fall directly over the femoral artery. If diminished pulsation is found other studies should be carried on in an effort to clinch the diagnosis.

## THE PRACTICAL DIAGNOSIS OF CONGENITAL HEART LESIONS AMENABLE TO TREATMENT

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*Augusta*

The diagnosis of congenital heart lesions was of academic interest only, until 1939. Until then, and all too often now, a blanket diagnosis of congenital heart disease was made. Such a diagnosis usually carried a poor prognosis. It is now possible to diagnose specifically 75 per cent, or three cases out of four of congenital heart disease, actually naming the lesions existing. With the specific methods of treatment now available it becomes all the more important to be able to diagnose the exact lesion or combination of defects present. Only those lesions which can be successfully treated will be discussed in this paper.

*Patent ductus arteriosus* was first attacked surgically by Gross of Boston in 1939. Since then it has been successfully

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attacked by a number of surgeons at many medical centers. The successful attack consists of ligation with or without sectioning of the ductus. The diagnosis of patency of the ductus depends on:

TABLE 1. *Congenital Heart Lesions Which Have Been Attacked Surgically.*

Patent Ductus Arteriosus.....	Gross—1939
Coarctation of the Aorta.....	Crafoord and Nylin—1944
	Gross—1945
Tetralogy of Fallot.....	Blalock and Taussig—1944
Vascular Constriction Ring (Persistent Right Aortic Arch).....	Gross—1945
Eisenmenger Complex.....	Blalock, Taussig and Harper—1946

1. The *typical murmur*, which is the single diagnostic feature. This is usually best heard over the first and second interspaces to the left of the sternum. It is widely distributed and well heard in the back over the left interscapular fossa. It is *continuous* in time with systolic accentuation. *This is most important.* With the exception of young infants, the murmur should always be continuous in order to make a diagnosis. Occasionally in infants it may be only systolic but soon becomes continuous as the child grows older. The murmur is produced by the sudden change in pressure from a high level in the aorta to a lower one in the pulmonary artery. The murmur is harsh and machinery-like in quality, sounding like the rhythmic whir of a dynamo or a humming top or the rush and roar of a train passing through a tunnel. This murmur is accompanied by a thrill in about one-half of the cases. Gross has seen two cases in which there were no murmurs at all. These cases were in failure with tremendously increased pulmonary pressure and thus no pressure differential between the aorta and pulmonary artery was noted.

2. The *peripheral signs* of aortic regurgitation may be present. The patent ductus actually creates functionally a form of aortic regurgitation; the wider the pulse pressure the larger the shunt. A capillary pulse, pistol shot femoral sounds, Duroziez'

double femoral murmur and a "water hammer" pulse are all observed in cases with large shunts.

3. The electrocardiogram is *not* typical nor diagnostic. Marked right axis deviation in the cardiogram always indicates the presence of some other lesion.

4. The cardiac silhouette on fluoroscopy is helpful but not diagnostic. Usually the pulmonary artery is enlarged and its pulsations are increased and the systolic impact of the aorta may be transmitted to the pulmonary circuit, producing a definite "hilus dance" or systolic pulsations of the major radicles of the pulmonary artery as seen in the lung hilus regions. The left ventricle is enlarged in about one third of the cases and the left auricle in about one half of the cases.

There is no cyanosis nor clubbing in uncomplicated patency of the ductus since the blood actually has a higher oxygen content.

In differential diagnosis two other lesions must be considered. An arteriovenous fistula or aneurysm, usually the result of trauma, and the rare instance of a syphilitic aneurysm rupturing into the pulmonary artery and producing a murmur identical with that of this condition, must be thought of in differentiation.

TABLE 2. *Diagnostic Features of Patent Ductus Arteriosus.*

1. Typical Murmur—Time; Location and distribution; Quality.
2. Peripheral signs of aortic regurgitation.
3. Fluoroscopy—Pulmonary Conus; "Hilus dance"; Left auricle and ventricle.
4. Cardiogram.

The *tetralogy of Fallot* was the second congenital lesion to be successfully attacked. This consists of pulmonary stenosis, interventricular septal defect, dextro-position of the aorta and right ventricular hypertrophy. Dr. H. B. Taussig, of Baltimore, reasoned that the bulk of the disabling symptoms in this condition were due to the impoverished blood supply to the

lungs as the result of the hypoplasia of the pulmonary artery and the pulmonic stenosis. Marked cyanosis, dyspnea, lowered exercise tolerance and decreased oxygen arterial saturation resulted from this. She thought that if an artificial ductus could be created by anastomosing an arterial trunk to the pulmonary tree, these phenomena could be helped. This turned out to be the case. Alfred Blalock first successfully did such an anastomosis in November of 1944. Since then he has done around 120 to 140 such operations with phenomenal success. Obviously, the correct diagnosis is all essential if operation is to be considered. Each of the four cardinal lesions contributes its diagnostic features.

Pulmonic stenosis results in cyanosis, clubbing, decreased exercise tolerance and decreased oxygen arterial saturation. It produces a systolic murmur which is harsh and best heard over the second interspace to the left. This murmur may not be audible if the pressure differential is equal on the two sides of the pulmonic valve. The x-ray typically shows a pulmonary concavity or evidence of hypoplasia in the anteroposterior view and in the left anterior oblique view the pulmonary window is unusually clear due to the hypoplasia of the artery.

The interventricular septal defect produces a typical Roger's murmur which is harsh, systolic, heard over the whole precordium, best in the 3rd and 4th interspaces to the left of the sternum and often accompanied by a thrill as is also the murmur of pulmonic stenosis. This murmur may be absent if the defect is quite large. Intraventricular block in the cardiogram may corroborate the presence of this defect.

Dextroposition of the aorta, in which the aorta overrides the ventricular septum and receives both venous and arterial blood, produces cyanosis, clubbing, decreased ex-

ercise tolerance and decreased oxygen arterial saturation. It also produces widening of the vascular stripe to the right of the sternum in the anteroposterior x-ray, often with a small or poorly visualized aortic knob. A right aortic arch is present in 20 per cent of the cases and may be diagnosed as mentioned later in this paper.

Right ventricular hypertrophy produces marked right axis deviation in the cardiogram in every case. A rounded, blunt shadow of the hypertrophied right ventricle may be seen in the anteroposterior x-ray and confirmed in the oblique views.

The tetralogy of Fallot must be differentiated from the tetralogy of Eisenmenger in which the essential points are identical with the exception of the fact that pulmonic stenosis does not exist. Therefore, under the screen and in the x-ray film there is seen a dilated pulmonary artery and the pulmonary window in the left anterior oblique view is encroached upon. This lesion contraindicates the anastomotic operation as here the lungs are getting too much blood supply. Transposition of the great vessels and the complete absence of one of the septa must also be considered, but these are unusually rare and these individuals rarely live beyond infancy.

TABLE 3. *Tetralogy of Fallot.*

1. Pulmonic Stenosis—Murmur, decreased P-2, transmission; Thrill; Cyanosis and clubbing; Decreased arterial oxygen saturation; Lowered Exercise Tolerance; Fluoroscopy—Pulmonary concavity; Small root shadows; Clear "pulmonary window."
2. Interventricular Septal Defect—Roger's murmur and thrill; I. V. block in EKG.
3. Right Ventricular Hypertrophy—Marked right axis deviation in EKG; X-ray and fluoroscopy; Precordial deformity and pulsation.
4. Dextroposition Aorta—Cyanosis and clubbing, etc.; Widened vascular stripe to right in X-ray and fluoroscopy; Small aortic knob or not visible; Right aortic arch in 20 per cent.

*Coarctation of the aorta* was first operated upon by Crafoord and Nylin (of Sweden) in October of 1944. Gross did essentially the same operation independently in early 1945. They completely excised the



area of coarctation and did an end to end anastomosis with a continuous mattress suture. Each has now done about six cases.

In coarctation of the aorta a ring or shelf of fibrous tissue constricts or encroaches upon the lumen of the aorta, usually just beyond the point where the left subclavian artery originates. This is often at the point where the ligamentum arteriosum joins the aorta. Diagnosis can be made by observing:

1. *Hypertension in the young.* This should always arouse a suspicion of this lesion. If the blood pressure is then taken in the legs it will be found to be equal to or lower than the brachial blood pressure. The femoral arteries are often impalpable and non-pulsatile or at least decreased in these respects.

2. In an effort to compensate for poor blood supply beyond the area of coarctation, a collateral circulation is established and this produces dilatation, engorgement and visible pulsation of the internal mammary and intercostal arteries. These pulsations may be seen and felt in the interspaces adjacent to the sternum and especially posteriorly beneath the angles of the scapulae. The dilated intercostal arteries often produce "scalloping" or notching of the under surface of the ribs, which can be readily seen in the x-ray.

3. Dilatation of the aorta, proximal to the coarctation, may often be visualized in the x-ray and demonstrated on percussion.

4. The aortic knob is usually hypoplastic or even invisible.

5. A systolic bruit is usually audible over the coarctation and is well heard in the back over the bodies of the vertebrae and in the left interscapular fossa, being well transmitted down the spine and along the course of the aorta anteriorly. A thrill may also be felt.

6. The cardiogram usually reveals some degree of chronic left ventricular strain.

7. The left ventricle shows evidence of hypertrophy in the x-ray and under the screen.

8. Hemiplegia in a young person should suggest the possibility of this lesion and is due to the coexistence of a congenital aneurysm of the Circle of Willis, which ruptures and produces the resultant syndrome.

We have seen two cases of coarctation in which the left subclavian artery was also involved, with no discernible blood pressure in the left arm in one, and a markedly diminished pressure in the left arm in the other. This may be called atypical coarctation of the aorta with involvement of the left subclavian artery. These cases will be reported in detail later.

The coexistence of coarctation of the aorta with Turner's syndrome must be thought of. This syndrome consists of webbed neck, cubitus valgus and infantilism.

The associated hypertension of coarctation of the aorta is now being attacked by Smithwick with his lumbodorsal sympathectomy in an effort to relieve the hypertension and its associated evils.

TABLE 4. *Coarctation of Aorta.*

- 
- |     |   |
|-----|---|
| 1.  | Suspect when hypertension is found in the young.  |
| 2.  | Femoral pressure lower than brachial.   |
| 3.  | Femoral arteries non-pulsatile or decreased.  |
| 4.  | Visible and palpable collateral circulation.  |
| 5.  | Proximal dilatation of aorta.   |
| 6.  | Hypoplastic aortic knob.  |
| 7.  | Scalloping or notching of the ribs.   |
| 8.  | Systolic bruit and thrill over coarctation.   |
| 9.  | Left ventricular hypertrophy in x-ray.  |
| 10. | Left ventricular strain in EKG.   |
| 11. | Hemiplegia, suggesting involvement of the Circle of Willis.   |
| 12. | Involvement left subclavian artery, rarely.   |
| 13. | Turner's syndrome—infantilism, webbed neck, cubitus valgus, (frequent association with coarctation of the aorta). |
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The final congenital lesion which has been successfully treated surgically is the *vascular constriction ring seen in cases of persistent right aortic arch*. Gross reports a successful operation in such a case in June 1945. In these cases constriction of the

esophagus and/or the trachea is produced by the ligamentum arteriosum and in some instances by one of the aortic arches if the aorta splits. Ligation and severance of the structures may effect a cure. This condition should be suspected in cases of unexplained dysphagia and in unexplained wheezing or respiratory difficulty, especially in infants. Diagnosis depends on the demonstration in the x-ray and under the screen of:

1. A shadow to the right of the sternum extending upward toward the right sterno-clavicular joint.
2. Absence of the aortic knob.
3. Displacement of the esophagus and trachea to the left.
4. Abnormal indentation of the posterior wall of the barium filled esophagus (retro-esophageal aortic knob).
5. Constriction of the trachea revealed by introducing iodized oil into the trachea with films in the A.P. and lateral views.

TABLE 5. *Vascular Constriction Ring Syndrome Persistent Right Aortic Arch*

1. Unexplained dysphagia, wheezing or respiratory difficulty, usually in infants or children.
2. Shadow to right of sternum.
3. Absence of normal aortic knob.
4. Displacement of esophagus and trachea to left.
5. Abnormal indentation of posterior wall of barium-filled esophagus (retroesophageal aortic knob).
6. Constriction of trachea revealed by introducing iodized oil into trachea with films in A.P. and lateral views.

### *Summary*

The practical diagnostic points useful in diagnosing the five congenital heart lesions amenable to surgical treatment have been emphasized. These five lesions, patency of the ductus arteriosus, the tetralogy of Fallot, the tetralogy of Eisenmenger, coarctation of the aorta and the vascular constriction ring with persistent right aortic arch, can be diagnosed correctly in a high percentage of cases (at least 75 per cent) by means of careful physical examination, fluoroscopy and electrocardiography.

The successful surgical treatment of these

entities represents a milestone in the therapy of heart disease and opens the door to an unthought of future in this field.

FOOTNOTE: Dr. Blalock, of Baltimore, wrapped the large, dilated pulmonary artery in a child with the Eisenmenger complex with cellophane early in July 1946. This was based on the idea that if increasing blood flow to the lungs in the tetralogy of Fallot relieves the distressing symptoms of limitation as is the case in the anastomotic operation, constricting the flow of blood to the lungs might well relieve some of the symptoms and signs of chronic congestion seen in the Eisenmenger complex. It was thought that by carefully gauging the pressure with which the pulmonary artery was wrapped with cellophane in order to predict the scar tissue production and thus predict the decrease in pulmonary artery flow, that such a procedure might be useful on the human after suitable animal experimentation.

This procedure was suggested by one of us (H.T.H.) to Drs. Blalock and Taussig in September, 1945. After a prolonged period of animal trial, Dr. Blalock tried this procedure on a child in July 1946. He succeeded in wrapping the pulmonary artery and the child woke up from the operation but died suddenly three hours later. The cause of death was not clear. It was probably due to pressure of the enlarged pulmonary artery on the trachea, since the child had had similar attacks of severe cyanosis and dyspnea precipitated by change in posture prior to the operation. Dr. Osler Abbott, of Atlanta, is said to have carried out this operation on one patient earlier this past winter with a definite reduction in pulmonary flow as measured by catheterization studies. Certainly these studies indicate that a fifth congenital lesion, the Eisenmenger complex, is probably amenable to surgical therapy.

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### ANIMALS FOR RESEARCH PURPOSES

Research on animals for the development of life-saving medical knowledge has been endorsed by the Chamber of Commerce of the United States in a statement of policy released recently by Howard Strong, Secretary of the Health Advisory Council of the Chamber of Commerce.

Mr. Strong announced the policy as the result of a referendum vote of member organizations. The statement submitted for the vote is as follows:

"In view of the great progress that has been made in preventive and curative medicine and surgery through animal research and the prospect of even greater progress in the future, the National Chamber is unalterably opposed to the prohibition of this scientific procedure. Such a prohibition would seriously hamper all medical progress."

Result of the vote was: 2,424 organizations in favor of the statement, 18 against. Represented in the poll were slightly over a million business men.

Mr. Strong, in a letter to Dr. A. J. Carlson, president of the National Society for Medical Research, announced the outcome of the Chamber of Commerce referendum and said, "We are therefore now in a position to present the chamber's opposition to any antivivisection legislation wherever such legislation rears its head and when advisable and possible, a representative of the Chamber can appear in opposition."



## SIMPLIFIED MANAGEMENT OF RELATIVE STERILITY

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*Augusta*

A vast number of relatively infertile women live in small communities whose only physicians are general practitioners. Most of these patients suffer in silence the humiliation and frustration of being unable to have wanted children. Too often the physicians of the neighborhood who care for their physical ills are of the opinion that sterility is out of their domain and that it lies in the field of special practice. Part of this is due to inadequate instruction when they attended medical school and much more to recital of elaborate and costly methods of diagnosis and management as reviewed in almost all of the papers in the medical journals upon the subject. Realizing the lack of attention to this subject by these physicians the women seldom seek other medical advice. What is more truly beneficial to society than the occasional overcoming of this bar to parenthood among worthy couples, and where will one find more grateful patients? Too often many of the procedures quite necessary for a truly comprehensive study are limited to those who specialize in at least the general field of gynecology and obstetrics or in the case of the male partner, urology. But even with the most thorough study of individual cases exhausting all knowledge upon the subject the percentage of success is far from perfect.

It must be emphasized that the condition of childlessness is in general a partnership affair between husband and wife and that the former must share in the responsibility. Various estimates as to the prime factors

lying with the husband vary. Stein<sup>1</sup> found the male partner responsible in one third of reproductive failures. Joel<sup>2</sup> found them responsible in 49 per cent of his cases. Williams<sup>3</sup> concluded that the husband and wife share about equally in the production of childless marriages. Meaker<sup>4</sup> and his co-workers consider that they share equally in sterility factors. Most authors agree that there are usually several aberrations. Meaker<sup>5</sup> states that there are found in the average childless couple 4.79 factors, each of which diminishes to some extent their capacity for conception. These factors may be genital or constitutional and are seldom limited to one partner. He no longer considers it sterility in men or women, but rather sterile mating between two relatively infertile individuals.

A simplified procedure eliminating for the time being, at least, the more complicated operations and limiting the study to the realm of activity of the general practitioner is surprisingly successful. Walter Williams<sup>6</sup> and Page and Page<sup>7</sup> have presented papers with a view to simplifying the study necessary.

It will now be demonstrated that some of the commonly accepted procedures are not so necessary and that some of the minor ones are too often neglected even by the experts. Everyone knows that the fallopian tubes must be open for the passage of the ovum. Sharman<sup>8</sup> in a study of 500 cases estimates that 25 to 30 per cent of primary sterility is due to non-patent fallopian tubes. Stein<sup>1</sup> found 20 per cent in 111 patency tests. One of the standard procedures is to test this function. Many have claimed to have produced patency in closed tubes by the diagnostic procedure of introducing CO<sub>2</sub> into the uterine cavity under controlled pressure. They, however, have no proof that the obstruction overcome was any other than spasm of the muscles. Furthermore,

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few women in private practice have had gonorrhea which is, for practical purposes, the outstanding cause of tubal obstruction. In addition, if they have been afflicted with this disease, there is usually some evidence as restriction of the motion of the body of the uterus and tender palpable masses in the adnexa besides evidence of infection as seen in the vulvar region—all of which should be readily detected by bimanual examination as used by any physician. Operative procedures to open closed tubes have not met with a great deal of success. By questionnaire Greenhill<sup>9</sup> studied the results of 818 plastic operations upon the fallopian tubes. This revealed that 54 pregnancies took place after operation, an incidence of 6.6 per cent, or one pregnancy in 15 operations. However, since only 36 live babies were delivered, the incidence of successful results was only 4.4 per cent, or one baby for every 22.5 operations. Ten of the 54 pregnancies (18.5 per cent) ended in abortion, and eight (14.8 per cent) were ectopic pregnancies. Hence only 66.7 per cent of the 54 pregnancies resulted in live children. Consequently, in the routine instance tubal insufflation, which carries a low but not to be ignored mortality may be dispensed with, reliance being placed upon a thorough bimanual pelvic examination to reveal any abnormal masses or restriction of mobility of the pelvic organs. Next to tubal patency in importance is the question as to the viability of the husband's sperms within the vaginal and cervical tracts. This is very easily ascertained, often at the very first visit, by arranging for the couple to have intercourse immediately preceding. The wife should take no douche thereafter and should be examined as soon as possible. Specular examination is then done before any other examination. The secretion aspirated from the cervical canal and also from the vaginal vault by aid of a medicine dropper is placed upon a slide and exam-

ined microscopically with low and high power objectives (Huhner test). While it is of interest to study the number, motility and shape of the sperms as is done by Moench,<sup>10</sup> Meaker<sup>4</sup> and others, it is not entirely necessary and a few specimens seen will generally give experience enough to give an idea as to relatively normal findings. Usually under low power the myriads of swarming minute tadpole-like sperms literally cover all areas of the field. Their presence in the cervical specimen is of more significance than in the vaginal one. If none, few or all dead ones are found in either specimen, it is of greatest import and an attempt must be made to find the cause. Among these is the fact that the high acidity of the vagina may have destroyed all or most of them. This is easily discovered by repeating the examination after the couple has had intercourse following an alkaline douche of 2.5 per cent sodium bicarbonate (two level tablespoonfuls to a quart of warm water taken with the patient lying down, preferably in a bath tub). If still no live sperms or very few are found the husband may logically be referred to an urologist. In lieu of a specialist the physician may undertake to improve the spermatogenesis. The main things to find and alter are foci of infection (teeth, tonsils, prostate), anemia, hypothyroidism, as determined by B.M.R. tests, etc. If the basal metabolic rate is low, thyroid extract should be given; and a high protein diet is indicated. Moench<sup>11</sup> found that practically every man who had deficient spermatozoa had a low basal metabolic rate. The common disorders found in the female are anemia, foci of infection, dietary deficiencies, especially in proteins and possibly in some vitamins.

A very common local condition often barring parenthood is cervical erosion which may usually be cured with one or two office cauterizations. Reis and Bernick<sup>12</sup> found



cervical disease in one half of 125 private patients complaining of infertility. Nearly one half of these became pregnant within a year without other treatment than electric cauterization of the cervix. Years ago Titus<sup>13</sup> stated that cervicitis with endocervitis is the most common cause of relative sterility. Care should be taken that cauterization is not too deep and not involving to any extent the cervical canal for fear of later stricture. A retroverted uterus ought to be replaced if possible and held thus by a Hodge pessary, which may be worn for several months. Some students insist that the most effective sperms are those which enter the cervical canal at intercourse. If this is true a Hodge pessary worn at the time may aid in depositing the sperms in the proper location. Variation in the position of the partners during intercourse may help in achieving this also.

Coequal with importance of patent fallopian tubes and the presence of potent sperms in the cervical canal is the presence or absence of ovulation. More and more evidence (Rock and Hertig<sup>14</sup>) is being accumulated to show that if the woman ovulates it ordinarily occurs fourteen days before the first day of the next due menstrual period. Some women fail to ovulate occasionally, while in others anovulatory periods are the rule. There have been discovered at least five methods of determining ovulation: (1) endometrial biopsy, (2) daily temperature charts (Tompkins,<sup>15</sup> Kleitman,<sup>16</sup> Klawns,<sup>17</sup> Greulich et al.,<sup>18</sup> Williams<sup>6</sup>), (3) electric potential changes of Burr,<sup>19</sup> (4) chemical estimation of the hormones, and (5) vaginal smear studies. Of all of these the daily temperature charts may be the simplest and most value to the practicing physician. It consists of taking the temperature by thermometer per mouth or per rectum or per vaginum, preferably

early in the morning after a night's rest and essentially at the same time and under the same conditions each day of the cycle. During the first portion of the cycle before ovulation, the temperature should be about one degree lower than during the portion of the cycle following ovulation. When charted the demarcation is rather decisive. The Planned Parenthood Federation of America, Inc., has printed charts for this purpose which may be obtained for a cent or two each. Endometrial biopsy has become an office procedure and with simple apparatus a strip of endometrium is obtained without much danger and without enough pain to warrant more anesthesia than that produced by a little morphine and hyoscine at most. This must be done after suspected ovulation, i.e., just prior to a menstrual period so that the changes in the endometrial glands produced by progesterone are evident to the pathologist who studies the specimen. Absence of ovulation is denoted by absence of progestational changes in the endometrium and characterized by lack of edema in the stroma cells and of waviness in the glands. It must be appreciated that normal women may fail to ovulate once in a while and several cycles must be studied if anovulatory periods are found.

As an adjunct to other studies the basal metabolic rate should be determined, especially if there is a tendency to menstrual disturbance, such as irregularity or hypermenorrhea, or if there is obesity present. If low, thyroid extract in adequate dosage should be given and controlled by B.M.R. determinations in addition to the well recognized subjective symptoms of overdosage. This has long been advocated by Meaker,<sup>7</sup> Litzenberg,<sup>20</sup> and more recently by Meaker<sup>4</sup> and co-workers, the Hamblen<sup>21</sup> group and by Rubin.<sup>22</sup> The use of other hormones, estrogen, progesterone, and gonadotrophic substances should be left to the research

student. Anemia and foci of infection (Meaker et al), must by all means be overcome. A high protein diet is desirable. The couple should be informed that success, if possible, may mean attention to detail for at least one year. It is essential that sperms be deposited in or near the cervical entrance about the time of ovulation. This time must be calculated for each woman. If she is regular in menstruation this is relatively easy to find (length of cycle, minus 14 days equals number of days to be added to first day of the last period.) Miller<sup>23</sup> has developed a chart for cycles of different lengths showing menstruation, sterile period and fertile period. Monthly routine procedure recommended is: (1) determination of probable time of ovulation, (2) sexual intercourse daily or every other day indulged in after a 2.5 per cent soda douche (two level tablespoonfuls of soda in one quart of water). The douche is taken warm, lying down (Brown<sup>24</sup> and Tew<sup>52</sup>). One tablespoonful of corn syrup may be added to the solution since it has been shown by MacLeod<sup>26</sup> that sperms are motile longer if supplied by such dextrose solution. The woman, after intercourse, must not rise up and the foot of the bed should advantageously be elevated throughout the night so that the semen has a tendency to remain in the upper vaginal vault bathing the cervix. Recently another solution for the douche has been recommended by MacLeod and Hotchkiss,<sup>27</sup> to wit: Ringer-glucose solution consisting of sodium chloride 9 Gm., potassium chloride 0.23 Gm., calcium chloride 0.22 Gm. and glucose C.P. 20 Gm. in 1000 cc. distilled water. They reported unusually impressive results.

NOTE: The object of this paper is to promote interest in this problem among general practitioners of the State and to aid in reducing the incidence of these tragedies of family life, of which almost every community has outstanding examples. A single success, almost more than any other one thing, enhances the value of the physician to his patients, and one successful case engenders others. It would be appreciated if triumphs and failures by this or any other management be tabulated and the results

presented to me. Recent research (Eastman<sup>28</sup>) has shown that youth is a better ally to pregnancy and labor as well as to child rearing than delay of several years' time. Consequently, the earlier in married life attention is paid to relative sterility the better.

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#### CANCER CONTROL A MAJOR HEALTH PROBLEM

Cancer control is a major health problem in the United States. As such, it merits attention not only in programs of research, but also in programs of education. Instruction concerning the nature of cancer and known methods of prevention and control should be included in the high school course of study, along with other important health problems facing the American people today. High school students are interested in such information. Scientific facts should be taught to them so that fears may be allayed, intelligent action as future adults be promoted, and families favorably influenced by the information which students relay to adult relatives.—*Joint Committee on Health Problems in Education*, 535 N. Dearborn St., Chicago 10.



## EARLY RISING AFTER MAJOR SURGERY

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G. FRANK JONES, JR., M.D.

*Augusta*

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There is now widespread interest in the manifest advantages and the possible disadvantages of early rising after major surgery. In the early part of this century it was particularly popular in Europe, and numerous favorable reports on this type of postoperative care have been reported by many European surgeons. At that time, Emile Ries<sup>1</sup> was practicing this type of treatment and getting encouraging results which he attributed largely to the accurate closure of the wounds and prevention of infection. In this country in 1911, Kelly<sup>2</sup> states the unfavorable reaction to early rising was probably due to the prevalent gross technic involving the use of coarse catgut and running sutures. Only the last few years have brought much renewal of interest in this type of treatment in our country. Newburger,<sup>3</sup> in a recent review, found that the ones who had given this procedure a thorough trial were almost uniformly favorably impressed. In general, critics of the practice have self-admittedly had little experience with it and have based their criticism on one or a few unfortunate complications, which may or may not have been justifiably attributed to early rising. The medical literature, mainly European, contains reports of many thousands of favorable cases and a mass of similar evidence is rapidly accumulating in this country.

Previously accepted conservative treatment implying 8 to 14 days of absolute bed rest was probably based largely on the teaching of Billroth, who believed rest and protection were essential for proper repair of

coapted tissue. In contradistinction to such an attitude is the belief that no increase in pain or frequency of wound disruption or hernia results, and that actual hastening of wound healing may follow early rising.<sup>4</sup>

The early rising of patients, along with postoperative breathing and coughing routines, is not being advocated as a substitute for, but as an adjunct to, the proved beneficial measures used in the care of the surgical patient. The uniformly good results listed in this type of treatment now are probably due to the proved good features of surgical technic and pre and postoperative care. This form of treatment probably would not be successful without gentle handling of tissues, accurate reconstruction of wounds, strict asepsis and antisepsis, adequate general and local pre-operative preparation, good anesthesia, proper preparation of the gastrointestinal tract, care as to the fluid balance, plasma and blood needs, and nutritional status of the patient. Very likely the reason this type of postoperative care did not retain its popularity when it was first advocated here was due to the fact that the pre and postoperative care of the patient was not as complete as it is at the present time.

Schafer and Dragstedt<sup>5</sup> in reporting early rising in 103 general surgical patients, found these patients to have a definitely lowered postoperative morbidity. They felt that the lowered postoperative fever was closely related to an observed improvement in respiration. They did not find any complications that might be blamed on the early rising of this group of patients. Leithauser and Bergo<sup>6</sup> in reporting a series of 436 cases (in which early rising was practiced) stated that no dehiscence, hernia, pneumonia, thrombophlebitis, or other serious complications occurred in the entire group. They stated that their records reveal that this type of postoperative care was a safe pro-

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From the Department of Surgery of the University of Georgia School of Medicine and University Hospital, Augusta.

cedure and decreased the atrophy from disuse of the sutured layers, and they thought that it might promote healing by improving circulation in the area of the wound. It decreased complications and morbidity by aiding respiration, increasing the tone and use of skeletal muscles, and thus improving the circulation in the pulmonary, systemic, portal, and lymphatic systems. It probably also promotes an earlier return to normal of urinary and digestive functions. Nelson listed 426 cases of early ambulatory treatment, the results of which were excellent. He felt that this plan of treatment was absolutely safe and that it represented a sound, surgical advance and recommended its more general employment in properly selected cases. In another paper, Leithauer<sup>8</sup> stated that he believed that the deleterious effects of surgical trauma were minimized by early rising. He showed that there was a marked lowering of the vital capacity following major surgical operations. This lowered capacity was in direct proportion to pulmonary complications. He further showed that early postoperative rising markedly cut down on the time and amount of the lowered vital capacity, and thereby decreased the incidence of pulmonary complications.

There is some difference of opinion as to the change in incidence of thrombophlebitis, phlebothrombosis, and pulmonary embolism in the early ambulatory cases, but it appears to be the preponderance of opinion that these complications are lowered in this group of cases.

For the past year we have used early rising for major surgical cases. This was begun quite cautiously. The first cases that we observed were those in which radical mastectomies had been performed. These patients did so much better than the previous cases of this type that we were encouraged

to try others. We carefully enlarged our selection of cases until now we have over 150 in which we have practiced this procedure. Included in this group are gastric resections, cholecystectomies, hernias, appendectomies, gastroenterostomies, exploratory laparotomies, cholecystjejunostomies and thyroidectomies. By far the major portion were abdominal cases. The first 100 consecutive cases are recorded to show the type of cases used in this series:

<i>Type of Operation</i>	<i>No. of Cases</i>
Inguinal herniorrhaphy.....	27
Gastroplasty .....	1
Gastroenterostomy .....	3
Exploratory laparotomy.....	9
Appendectomy .....	16
Closure of perforated peptic ulcer .....	1
Gastric resection .....	4
Mastectomy .....	10
Epigastric herniorrhaphy.....	2
Umbilical herniorrhaphy.....	3
Supraumbilical herniorrhaphy.....	1
Thyroidectomy .....	10
Cholecystectomy .....	8
Cholecystjejunostomy .....	2
Femoral herniorrhaphy.....	2
Resection rectosigmoid.....	1
	<hr/> 100

We have been very careful in selecting the patients in whom this procedure has been tried. Practically the only cases that have been used are ones which were in good general condition when the operation was performed. Early ambulatory treatment was not tried on patients who were acutely ill or those who had peritonitis or abdominal distention. On most of the appendectomies, McBurney incision had been made. These wounds were closed as previously, using catgut. Most of the other incisions for intra-abdominal operations were vertical and the major portion of them were paramedian incisions. As a rule continuous chromic No. 1 catgut was used on the peritoneum and posterior rectus sheath, and interrupted black silk sutures were used on the anterior rectus sheath, no tension sutures being used. However, on the gastric resections upper midline incisions were used. Our hernias were closed with interrupted black silk sutures throughout.



Cases that we considered in the early ambulatory group were routinely got out of bed on the first postoperative day (within 24 hours after surgery). The routine consisted of the patients sitting up slowly, and then sitting on the side of the bed swinging the feet until the weak and dizzy sensation passed off. We would then have the patient stand up and exercise the legs momentarily, and then walk to a bedside chair and sit down. On the first occasion the patient would sit up only 5 to 10 minutes. When the patient first got up, some member of the staff would supervise the procedure. The patient was encouraged not to get up without attendance for the first two postoperative days and was advised to get up several times a day, increasing the frequency and the amount of time of sitting up and walking, depending on state of feeling. We would encourage the patient to take deep breaths and cough when he was up in the vertical position. As a general rule, by the third or fourth postoperative day the patient was able to be up and around the ward alone, taking care of a large portion of his needs, and frequently helping some of the other patients who were bedridden. The demand on ward nurses was thereby appreciably decreased.

It is impossible definitely to convey the favorable impression that we received in observing the postoperative courses of these patients. I know of no exact way to compare this group of patients with controls by charts or figures. The difference was not in any specific thing but the general condition of the patient as a whole. I think that the most striking feature was the vigorous appearance of these patients. They appeared largely to escape the usual postoperative asthenia. It was an unusual feeling at first to come in the ward and see a patient's bed empty on the third or fourth day after a major surgical procedure and then find him

in the bath room shaving. Another important factor about these patients was their mental attitude. They seemed to miss to a great extent the depression that is common with ill patients and the usual postoperative cases. They gave the impression of feeling much more cheerful and cooperative. Another noticeable factor was the more prompt return of the normal functions of the different systems. Fewer catheterizations were performed and the gastrointestinal system returned to normal sooner. It was found that a large number of these patients did not require the usual postoperative enema. We also got the impression that the postoperative morbidity in these patients was less. Undoubtedly their respiratory systems could function more normally and the pulmonary complications were cut down. A large part of the basal atelectasis associated with the elevated diaphragms and inadequate drainage in the non-ambulatory cases was avoided. Most of these patients did not leave the hospital any earlier than usual because they were kept in for observation. However, they are now beginning to leave much earlier and it is obvious that it will be a significant financial factor and allow a larger turnover of patients per bed.

We will use one case as an illustration of what we believe will be one of the most beneficial factors in this type of treatment.

A well preserved 90 year old man came into the hospital with a moderate sized inguinal hernia. He had first noticed the hernia two years before. It rapidly increased in size and in the past few months had become incarcerated several times with symptoms of impending strangulation. He could not keep it reduced with a truss and it was beginning to inactivate him very much. In fact since the last time it had become incarcerated, which was several days before, he was afraid to be out of bed for any length of time. A thorough examination revealed no contraindications to surgery other than the possibility of genitourinary complications due to a hypertrophied prostate. A urologic consultation confirmed that this was no real contraindication, since there was practically no residual urine. The patient was operated on under field block anesthesia and allowed to get up immediately after the operation. There was no demonstrable change in the patient's postoperative clinical chart. His temperature had risen as high as 99.2 pre-operatively; the highest postoperative temperature was 99.2. He showed no ill effects from the operation and was dismissed from the hospital on the fifth postoperative

day. Follow-up on the patient since then has revealed nothing unusual. Certainly, this type of postoperative therapy should be a very helpful factor in handling elderly surgical cases.

This report recounts the favorable results that we have observed in early postoperative ambulatory cases. We have failed to find any disadvantages to, or a single complication arising from this procedure.

### Conclusions

A report of over 150 cases in which early postoperative ambulatory treatment has been practiced reveals no incidence of wound disruptions, hematoma or delayed wound healing, hernia, or thrombo-embolic phenomena.

It is believed that this is a definite added advantage in postoperative care and that it is a physiologic type of therapy.

We believe that the selection of the cases in which this practice is to be followed is very important and that without proper attention to all details in pre and postoperative therapy and special care in the surgical technic of wound closure, the procedure is not without hazards.

FOOTNOTE: It is of additional interest that the principle of early rising as here outlined in general surgical cases has been found equally applicable in patients with major intrathoracic operations.<sup>9</sup>

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### ART PRIZE CONTEST

The \$34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the A.M.A. at Atlantic City June 9-13, 1947.

Art works on other subjects may also be submitted for the regular cups and medals.

For full information, write Dr. F. H. Redewill, Secretary, American Physicians Art Association, Flood Building, San Francisco, Calif., or to the sponsor, Mead Johnson & Company, Evansville 21, Ind., U. S. A.

## DOCTOR NATHANIEL BROWNSON (YALE 1761)

JOSEPH KRAFKA, JR., M.D.

University of Georgia School of Medicine.  
*Augusta*

Dr. Nathaniel Brownson was one of a group of Connecticut yankees who left a definite impression upon the politics of Georgia during the Revolutionary period. While he has never had the public notice of his colleague, signer Dr. Lyman Hall, his career paralleled that of the more famous practitioner in many details. He was a graduate of Yale in 1761; twice a delegate to the Continental Congress; governor of the forming State of Georgia in 1781; and politically active until his death in 1796.<sup>1</sup>

According to Jones he had an M.D. from some unidentified Northern school, but it is more probable that he got his training under the preceptor system. He came to Georgia under the influence of Dr. James Dunwoody of Midway, a physician with whom he was very closely associated throughout the rest of his life. He purchased a small plantation two miles from Riceborough in St. John's Parish, which later was to be renamed Liberty County.

His political history begins with his appointment as a delegate from St. Johns to the Provincial Congress held at Tondee's Tavern July 12, 1775, when that body adopted the American Bill of Rights.<sup>2</sup> He was immediately placed on a committee to impress and organize the militia.<sup>3</sup> The Congress adopted a provisional constitution April 15, 1776<sup>4</sup> which was further elaborated in 1777.

Brownson took his seat under President Bulloch on the Council of Safety in June 26, 1777.<sup>5</sup> The council published a list of names of men considered dangerous to the "cause of liberty" and on that list appeared



the name of Dr. William Read who was later to be shown a true patriot and a close associate of Brownson. Dunwody was also a member of the council in August, 1776. Brownson continued as a leader, was placed on a committee to confer with General Lee concerning the provisions to be made for a campaign against the Tory stronghold at St. Augustine. Brownson was also on the committee appointed to take security from Captain Sam Miller commissioned to fit out a coast vessel.<sup>6</sup>

There is no record of his activity for the year 1777, but from his subsequent history it may be inferred that he was in the Army in the capacity of a surgeon's mate, since he is so listed by White in his *Historical Collections*<sup>7</sup> together with Adam Alexander, James Houston, Thomas Davenport, Fred Ridgely, while David Bradie is listed as surgeon. At one place in the *Revolutionary Records* he is listed as a refugee until June, 1781.<sup>8</sup> He received an appointment in the Continental Army as Deputy Purveyor of Hospitals for the Southern Department, a position which he held from June until August.<sup>9</sup> This was a post of considerable importance since only twenty-three surgeons held this rank in the whole army.<sup>10</sup>

When the British were forced to withdraw from Georgia in August 1781, the Free-men in the State met at Augusta, and Brownson was first elected to the post of Speaker and then unanimously chosen Governor.<sup>11</sup> The new Speaker drew up a memorial as follows:

Sir:

The Representatives of this State having unanimously elected you Governor for the present year, it is with pleasure I am commanded by that body to signify their choice unto you.

A knowledge of your character, your integrity and determined conduct, have induced the House at this period to select you for that important trust, a period, Sir, when notwithstanding, it has pleased Almighty God to crown our cause with the most signal success. Our Country is still invaded by public and infested by private enemies.

It is our duty to fall on such measures to counteract the former and prevent the latter from preying on the vitals of our State. We make no doubt we shall meet with your assistance and exertions in a laudable undertaking and we assure Your Honor we shall pay the

greatest attention and regard to any affair of public consideration you may think necessary to recommend.

JOHN JONES, *Speaker*

#### The Governor's answer:

Your unanimous choice of me to the first Magistracy of this State signified to me by your Speaker does me unmerited honor.

The favorable sentiments you are pleased to express of my character inspire me with a desire of meriting such approbation; deeply impressed with a sense of importance of the trust and my want of abilities unaided by your counsels and exertions, I should have declined so arduous a task, but relying upon your advice and assistance, I shall make every effort to carry into effect such measures as you shall devise. Effectually to secure this State against machinations of public and private enemies, and establish the peace and tranquility of this once flourishing country on a permanent foundation.

Imprest with the highest sentiments of esteem and respect.

I have the honor to be

Gentlemen, etc.

NATHAN BROWNSON<sup>12</sup>

While Governor Brownson's administration was comparatively brief, running from August, 1781 to January, 1782, many important bills were passed. He issued first a proclamation asking that fugitives to other states return and help defend their property or suffer three-fold taxation. Those in South Carolina were given thirty days to return, in North Carolina sixty days and in Virginia ninety days.<sup>13</sup> Election of justices was next undertaken and courts were established. The position of Director General of State Hospitals was created and the place filled by Dr. James Dunwody. Continuation laws were passed; property of Tories sold; delegates were elected to the Continental Congress; a Georgia state legion was organized and land awards were made to Colonel Elijah Clarke. Brownson was allowed the sum of 50 pounds for secret services.<sup>14</sup> He joined Dunwody in a vote of aye for a bill proposing that the members of the Assembly serve gratis.

In 1778 the Provincial Legislature had passed an act to define treason and in 1781, by the continuation laws, Brownson was authorized to carry out the provisions against the enemies of the State.<sup>15</sup>

Brownson himself had been named on a list subject to the British Disqualifying Act of 1780,<sup>16</sup> and again on the British Bill of

(Continued on page 303)

# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

OCTOBER, 1946

## GEORGIA VETERANS' PROBLEMS

With the return home of most of the men and women who served in the recent war, the personnel of the various agencies of our government have worked tirelessly to solve the problems of these veterans, and the problems of the veterans of other wars as well. To the Veterans' Administration has been delegated, for the most part, this job.

These governmental agencies, particularly the Veterans' Administration, need now the services of a large number of qualified physicians. The various state medical associations have set up various plans with the view of cooperating medically with these agencies. The Council of the Medical Association of Georgia, at a meeting in Atlanta, Sept. 22, 1946, discussed with officials of the Veterans Administration their medical problems in Georgia. It was learned that there is now an accumulation of 8,000 cases for our State, adjudication of which has been delayed because of no medical examinations, inadequate medical reports, or no reports at all. The Council agreed to ask the members of the Association to cooperate in a program to facilitate medical examinations and medical care for these veterans. In the discussion of the problem it was pointed out that if each physician in Georgia would accept the responsibility to examine and render an adequate medical report for those veterans *properly referred* to him or her, this group of unfinished business could soon be eliminated.

Each member of the Association will re-

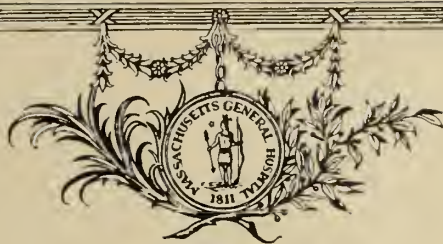
ceive a communication from the office of the Secretary-Treasurer asking him or her whether or not he or she desires to participate in this undertaking to help the veterans. Upon receipt of a reply the Secretary will note on the proper roster the wishes of the member regarding this work. The names of those physicians who indicate a willingness to help in the work of the Veterans Administration will be transmitted to the proper authorities of that agency. No physician should proceed with any *official* medical work for a veteran until he or she has been duly authorized by the Veterans' Administration to do so.

## CELEBRATION OF THE CENTENNIAL OF ANESTHESIA AT THE MASSACHUSETTS GENERAL HOSPITAL

The Massachusetts General Hospital has sent out invitations to the celebration of the centennial of the *first public demonstration* of surgical anesthesia in that venerable institution, October 16, 1846. The handsome invitation issued is reproduced in this Journal. The program of exercises, October 16, 1946, includes addresses by Raymond B. Fosdick, president of the Rockefeller Foundation, Dr. Evarts A. Graham, professor of surgery, Washington University, and Dr. Henry K. Beecher, professor of anesthesia, Harvard University.

This event is typical of the activities of this Massachusetts hospital in keeping alive the memory of Morton's administration of ether one hundred years ago. The unabated persistence of the institution in the matter accounts in no small measure for the acceptance of Morton as the discoverer of anesthesia by a large proportion of the medical profession and the laity. In season and out of season Morton's achievement is kept before the public, which increases the fame of the Boston dentist, and also reflects credit





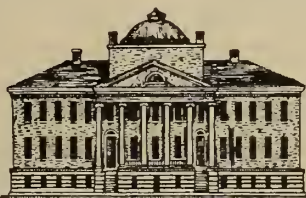
COMMEMORATION  
*of the*  
 One Hundredth Anniversary

*The First Public Demonstration  
 of Surgical Anaesthesia  
 at the  
 Massachusetts General Hospital  
 Boston October 16<sup>th</sup> 1846.*

*The Trustees and the Staff  
 Request the Honour of your Company  
 October 16<sup>th</sup> 1946*

*Harry Kux Sherrell*  
*For the Trustees*

*Nathaniel W. Faxon*  
*For the Staff*



upon the place where the event took place. Every October 16 is observed by this hospital as "Ether Day," when a speaker of national prominence addresses a large audience.

It was one of these Ether Day speeches which influenced the majority of electors of the New York University Hall of Fame to declare Morton as the discoverer of anesthesia and place him in that category in their

Hall of Fame. This speech was the one made by the late Dr. William H. Welch ("Popsy"), of Johns Hopkins. In a personal letter to me some time later, written in longhand, as he frequently did, Dr. Welch stated that all the one hundred electors who decide every five years who wins a coveted niche in the great hall were sent a copy of his Ether Day address, which naturally was most favorable to Morton, while

they received but little, if any, information about other claimants to the great distinction. Two other doctors of medicine were members of the group of electors at that time, Drs. W. J. and C. H. Mayo. The other electors were scientists, educators and writers whose vote on a medical subject was bound to be affected by the arguments of such a foremost physician as was Dr. Welch.

During World War I, while visiting another United States military hospital in France, I noticed several medical officers wearing the same kind of flower on their uniforms. "What is the meaning of this?", I inquired. "Why, don't you know, this is the 16th of October," was the reply. "Well, what of it?" I asked, and received the answer, "This is the anniversary of the discovery of anesthesia at the Massachusetts General Hospital, and we as alumni of that institution are observing the day." And there they were doing it, thousands of miles from home, in the midst of a great war. I had to hand it to these men for loyalty. No wonder so many people believe Morton discovered anesthesia.

How I wish Georgia doctors would become this enthusiastic over the real first anesthetic, that given by a Georgia doctor in Jefferson, Georgia, March 30, 1842, four and one half years before Morton gave his first anesthetic. We commemorate Crawford Long Day in Athens every 30th day of March, and all members of the Medical Association of Georgia know about it and are invited to it, but it is a rare thing ever to see as many as a half dozen doctors present.

We congratulate the Massachusetts General Hospital upon this historic occasion, and wish for it the greatest success, and a long continuation of similar celebrations.

FRANK K. BOLAND, M.D.

## POSTOPERATIVE EARLY AMBULATION

The practice of "getting 'em up early and out of the hospital" is a fine one—for the other doctor's patient. This is the attitude the average surgeon takes in the case of his own patients. As a rule he prefers to use a middle of the road, conservative routine in getting his own patients out of bed. No one can criticize this attitude, but the purpose of this editorial is to show the practical benefits derived from early ambulation to the patient, to the surgeon, and to our own crowded hospital facilities.

The common conditions arising postoperatively that torture the patient and plague the surgeon are (1) nausea and vomiting, (2) urinary retention, (3) gas pains and abdominal distention, and (4) pain in operative wound.

If we could eliminate these four problems, surgery would be a pleasure both to the patient and to the doctor. With the advent of pentothal sodium the first of these conditions has practically disappeared. Postoperative nausea usually means either a sensitivity to opiates, dehydration with acidosis, or occasionally paralytic ileus. Early ambulation—getting the patients up in a chair for 10 to 15 minutes twice the first postoperative day, and usually making them walk the next—will cut postoperative nausea and vomiting by reducing the amount of morphine a patient will require. It also helps to prevent paralytic ileus by maintaining normal muscle tone in the abdominal wall and by facilitating the early establishment of normal bowel movements.

Urinary retention with catheterization plagues the male patient particularly. Getting a patient on his feet aids materially in helping empty his bladder. The mastery of the bed pan and urinal is a great accomplishment as anyone who has been kept flat



on his back for two weeks can readily testify.

Gas pains and abdominal distention are the chief causes of postoperative discomfort. More hypodermic injections are given for these conditions than for any other. If you eliminate gas your patient has a smooth convalescence, with a minimum of pulmonary complications. Getting the patient up early and permitting him to use a bedside commode effectively, combats gas and abdominal distention. Nothing causes more tension on a wound than a distended abdomen; this also is one of the chief causes of evisceration.

Early ambulation causes very little pain in the operative wound itself. Active abdominal movements and early walking seem to remove the soreness which so often persists for weeks about the wound. Only in herniorrhaphy, due to usual procedure of suturing the abdominal muscles to Poupart's ligament, is movement very painful. This is true whether on the first or on the fourteenth postoperative day.

Early ambulation naturally can't be practiced unless non-absorbable suture material is used. Very few of us are willing to trust catgut alone, unless on a muscle splitting incision as a McBurney. The most commonly used suture materials are silk, cotton, stainless steel wire and tantalum wire. Karl Meyer of Chicago has employed a technic where interrupted silk is used in the peritoneum and posterior rectus fascia; and tantalum wire is used as a figure eight buried suture in the anterior rectus fascia. No retention sutures are used. This routine is the one I have utilized since 1945, when Dr. T. C. Davison, of Atlanta, with whom I was associated, introduced it to me (except No. 32 stainless steel wire is used instead of tantalum, which is expensive).

The usual objections presented when early

ambulation is discussed are: (1) It might increase adhesions and cause intestinal obstruction; (2) the danger of evisceration, and (3) the probable increase in postoperative hernia. My answer to these problematical conditions is that, during the past two years, when several hundred abdominal cases have been gotten out of bed on first, second, or third postoperative day, none of these complications occurred. I have had gallbladder and stomach cases, hysterectomies, and of course the usual appendectomy case, through a right rectus or battle incision, up on the first or second postoperative day without any complications. All of these patients who had experienced previous surgery remarked how much better they felt when made to get up early. When a woman who had a hysterectomy two days previously tells you she feels better than when she had her appendix removed several years ago, it makes one enthusiastic about "getting 'em up early."

There is no need to discuss the decrease in the incidence of phlebothrombosis and pulmonary embolism. It is non-existent when early ambulation is practiced.

The average hospital stay of my patients since early ambulation has been practiced has been cut five days. Most of them want to go home as soon as they start walking (usually on third or fourth postoperative day). However, it is customary to keep them seven or eight days until the skin sutures are ready to be removed (This procedure saves me a trip to their home). In the crowded Atlanta hospitals how many empty and hence available beds would be gained by cutting five to seven days from the average patient's hospital stay?

#### *Summary and Conclusions*

1. With the use of non-absorbable sutures and careful technic it is safe to get most abdominal operative cases out of bed on the first or second postoperative day.

2. By practicing early ambulation the patient has a more uneventful recovery, with the reduction of nausea and vomiting, gas and abdominal distention, urinary retention and general discomfort.

3. The patient leaves the hospital without having become debilitated and is thereby able to return to his usual duties 2 to 3 weeks sooner.

4. The average hospital stay will be shortened from 5 to 7 days by early ambulation.

STERLING H. JERNIGAN, M.D.

### STUDY SHOWS HOW STREPTOMYCIN FIGHTS DISEASE GERMS IN BODY

*National Research Council Report Urges Long-Range Study to Prove Drug's Value Against Tuberculosis*

In the most comprehensive report issued since streptomycin was first described in 1944, the September 7 issue of *The Journal of the American Medical Association* reviews the results obtained in the treatment of 1,000 cases of various infections with this gallant new antibiotic drug which is derived from a soil microbe.

The report, based on a study carried out by 55 investigators, was prepared by the Committee on Chemotherapeutic and Other Agents of the National Research Council, composed of Drs. Chester S. Keefer, of Boston, chairman; Francis G. Blake and John S. Lockwood, both of New Haven, Conn.; Perrin H. Long and E. K. Marshall, Jr., both of Baltimore, and W. Barry Wood, Jr., of St. Louis.

The committee's report was released shortly after the Civilian Production Administration announced that designated hospitals would begin limited commercial distribution of streptomycin. More than 1,600 general hospitals have been selected as depots for the drug, and they now are supplying other hospitals in their respective areas. Heretofore streptomycin was available only in small amounts and this was distributed by the Civilian Production Administration to the Army, the Navy, United States Public Health Service, Veterans Administration and the National Research Council for integrated clinical research.

#### *Million Dollars to Finance Program*

Producers of streptomycin contributed nearly a million dollars to finance the committee's program.

The drug was discovered by Dr. Selman A. Waksman at the New Jersey Agricultural Experi-

ment Station, Rutgers University, New Brunswick. Waksman and a young assistant, Dr. Albert Schatz, came upon their discovery while working with a soil microbe called *Actinomyces griseus*. They had found two specimens of this creature: one from a piece of highly manured soil on the college farm, the other in a swab taken from the throat of a chicken. This griseus looked like a brilliant performer right from the start. It attacked and killed scores of disease bacteria. Its chemical killing stuff was extracted and named streptomycin. Since that time the drug has been used experimentally in scores of laboratories and clinics throughout the country and now medical science is able to evaluate the results of its use against many diseases.

From time to time, the new drug has been acclaimed as effective against tuberculosis. Touching on this phase of research, the committee's report says:

"When the program of the committee was started on March 1, 1946 it was impossible for us to develop a wide study of tuberculosis. Only the cases that were already under investigation prior to March 1 were continued in order to complete this human experiment. This policy was necessitated by the small supplies of streptomycin available and the magnitude and long-range nature of the problem. It is the hope of the committee that adequate ways and means may be found for studying the application of streptomycin to tuberculosis so that its place in the treatment of this disease can be defined."

#### *Report on Tuberculosis Studies*

One section of the report deals with the experimental studies of streptomycin in tuberculosis which were carried out by H. C. Hinshaw, M.D., Ph.D., Division of Medicine, and W. H. Feldman, D.V.M., M.S., Division of Experimental Surgery and Pathology, Mayo Foundation. Their studies demonstrated that "streptomycin has a powerful effect in inhibiting the growth of tubercle bacilli in experimental tuberculosis of guinea pigs. Many pigs can be saved by treatment and in 30 per cent the organisms cannot be isolated from the organs of the surviving animals."

Dr. Hinshaw studied 75 patients with various forms of tuberculosis over a one and a half year period.

Twenty-four of these patients suffered from pulmonary tuberculosis and all of them were given streptomycin. "In general," the report says, "patients with a grave prognosis (forecast as to recovery) were selected for investigation—that is, patients who had not improved on conventional forms of therapy. Patients who had had collapse therapy were excluded from the study."

#### *List Five Patients as Failures*

"Five are listed as failures. Two of these are so regarded because they died, although they



showed some improvement by x-ray prior to death and were in the terminal stages of their infection prior to treatment. The other three were regarded as failures since they showed no benefit, although they also got no worse. So far Dr. Hinshaw has not observed pulmonary tuberculosis extending into previously uninvolved areas of lung during streptomycin treatment, in spite of the fact that lesions were extending prior to institution of therapy. He has witnessed recurrence of progression of tuberculosis following the discontinuance of therapy, when beneficial effects had been observed while under treatment. This occurred in four of 19 patients who showed regression of the disease process while under treatment . . .

In summing up, Dr. Hinshaw expressed the opinion that, if his work is confirmed, streptomycin is very likely to prove valuable as a palliative remedy in tuberculosis, at least because of its apparent suppressive action. In his experience *it did not eradicate infection*. Clinically, such a suppressive measure would be of tremendous value as a stopgap measure to be taken prior to or following other forms of treatment, including surgery." In conclusion the report says:

#### *Committee Urges Extensive Study*

"Tuberculosis of various organs needs to be studied more extensively with streptomycin. A long-range program should be planned and the patients followed for a minimum period of five years. From the experience which has accumulated so far, it appears that a minimum period of three to six months treatment will be required and in some cases it will be necessary to treat patients for a longer time. Since streptomycin has an inhibitive effect on the growth of the tubercle bacillus, and since the exudative lesions do not progress while the patient is under treatment, this agent should be helpful in tuberculosis when it is combined with other established methods of treating this infection."

The committee says that from the evidence accumulated so far, streptomycin is "the best agent available" for the treatment of tularemia or rabbit fever. This disease is carried by rats, rabbits and 20 other animal species. It strikes 1,000 or more persons, mostly hunters and butchers, in the United States each year. The disease rarely kills over five per cent of its victims, but leaves the rest of them debilitated to a point where they may be bedridden for months.

#### *Obtain Best Results in Tularemia*

Streptomycin was tried in 67 cases of tularemia, with 63 recoveries. "The results were striking and immediate in 55 and gradual but permanent in eight. Nearly every patient was treated with one gram per day for an average of seven days. The majority of cases had been treated previously with sulfonamides and penicillin."

The committee says that "extremely favorable results have been obtained" in the treatment of

Hemophilus influenzae meningitis when injections of streptomycin were started early in the course of the disease. Influenzal meningitis has nothing to do with the disease usually called influenza. Rare in adults, influenzal meningitis is not infrequent in children. About 85 per cent of the cases occur in the age period from two months to three years. Mortality is high.

Streptomycin, the committee adds, should be used in all cases of bacteremia—those diseases caused by bacteria in the blood stream. The drug was used in 91 cases. Forty-nine patients recovered and 12 improved. In four there were no appreciable effects, although the patients survived. Twenty-six patients died. "The evidence is good," the report says, "that the streptomycin exerts a favorable effect in clearing the blood of organisms and influencing the local infection."

#### *Effective in Urinary Tract Infections*

The investigators found that streptomycin is especially effective in urinary tract infections which plague older persons. It sweeps this type of infection away in a few days. The 409 cases of urinary tract infection were caused by a great variety of bacterial species. The overall recovery rate was 42 per cent. A high percentage of the cases were chronic infections of two months to 20 years duration. Of the patients who improved, 19 per cent relapsed after treatment was stopped. Almost all of these infections had been treated previously with sulfonamides and penicillin.

The results in the treatment of typhoid fever, Salmonella (a group of germs responsible for many cases of food poisoning) infections and brucellosis (undulant fever) "have been disappointing in that there is no convincing evidence that the course of the disease in any of these infections is shortened," the committee's report says, adding: "Too few patients with typhoid have been treated to ascertain whether the fatality rate can be reduced, and patients with brucellosis have not been followed long enough to determine whether the relapse rate can be reduced. In any event, no dramatic results have been observed in any of these infections."

#### *Note Minor Toxicity From Drug*

The committee also reported on the toxicity of the drug. In the 1,000 cases covered in the survey the overall incidence of untoward side effects was 20.5 per cent. "It was plain that the incidence of the reactions increased with the total daily dose. When the average daily dose was over one gram there was a striking increase in the number of reactions." The commonest reactions were headache, fever, skin eruptions, flushing of the skin and dizziness.

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

## GEORGIA DEPARTMENT OF PUBLIC HEALTH

### ROCKY MOUNTAIN SPOTTED FEVER IN GEORGIA

Rocky Mountain spotted fever was for many years known only in the western part of the United States. Since about 1930 the disease has spread to various sections of the country, including the South. In Georgia, 96 cases have been reported during the past fourteen years. Fifty-five (57.3 per cent) occurred during the past three years (Table 1). Of these 55 cases, all were white, 25 females and 30 males. Data on the age of the patient were obtained for 51 cases and showed that 44 were under eighteen years of age. The youngest patient was twenty-one months old; the oldest seventy-two years. There have been 11 deaths during the past three years, four occurring in 1944, five in 1945, and two in 1946.

TABLE 1  
*Rocky Mountain Spotted Fever in Georgia*  
1933-1946

1933-1939 . . . . .	8
1940 . . . . .	15
1941 . . . . .	6
1942 . . . . .	6
1943 . . . . .	6
1944 . . . . .	12
1945 . . . . .	18
1946 (through August) . . .	25

The disease is widely distributed throughout Georgia, having been reported in forty-six counties, the greater number of cases being reported from the northern section of the State. The highest endemicity during the past three years was in Fulton and DeKalb counties which had 15 cases.

Rocky Mountain spotted fever, being transmitted by infected ticks, has a seasonal incidence coinciding with the season of greatest activity of the ticks. In Georgia, records of the 96 cases occurring during the past fourteen years show 14 cases in May, 34 in June, 27 in July, 11 in August, 6 in September, 2 in December, 1 in January, and 1 in April. Thus, 92 (95.8 per cent) of the cases occurred during the period May through September.

The onset of spotted fever is usually sudden with rapidly rising temperature (103-106° F.), chills or chilly sensations, severe headache, backache, muscular soreness and marked prostration. Nosebleed is not uncommon. The temperature remains high during the first ten days with irregular remissions, usually during the mornings of 1 to 3° F., after which it gradually falls by lysis, terminating about the twenty-first day. As the disease progresses the pulse rate may range from 110 to 140 or even higher, just before death. Restlessness, insomnia, and marked hyperesthesia are often distressing features.

The most characteristic feature of spotted

fever is the rash, which appears between the second and fourth day—occasionally as early as thirty-six hours or as late as the fifth day. The rash may be preceded by a faint mottling of the skin suggestive of the early rash of measles. The first specific lesions are macular, discrete and rose-red in color, blanching on pressure and varying in intensity, becoming fainter or deeper in color with the fall and rise of fever. The lesions become more distinct each day until they no longer blanch on pressure and become definitely petechial, especially on the extremities. During the first few days after the rash appears, lesions in varying stages and development may be seen. In severe infections they may increase in size, and become deep red or purplish, and occasionally necrotic. However, they rarely coalesce. The appearance of ecchymotic blotches usually indicates an early fatal termination.

In patients who survive the rash persists well beyond convalescence, becoming brownish, and may be visible on the extremities for many months after complete recovery.

Clinical diagnosis of Rocky Mountain spotted fever frequently necessitates its differentiation from murine (endemic) typhus fever. The chief distinguishing features are noted on page 301 of this Journal.

The Weil-Felix agglutination reaction is a valuable aid in the diagnosis of spotted fever. It is usually negative during the first week after onset, becoming positive during the second or third week. Since this reaction is usually positive for both spotted fever and murine typhus, no differentiation can be expected from this test. However, a complement fixation test is available and offers valuable differential laboratory aid.

The only specific treatment is anti-Rocky Mountain spotted fever rabbit serum, which must be administered just prior to, or not later than three days after appearance of the rash. The dosage is 1 cc. per kilogram of body weight, given intramuscularly. The entire amount must be administered within twenty-four hours. There is some evidence that paraaminobenzoic acid is beneficial if given early in the course of the disease but its value has not yet been established. Antibiotics and sulfonamides are of no value in this disease. Intravenous therapy of any kind is to be discouraged. Hypnotics to control restlessness and pain, abundance of fluids to counteract dehydration, liberal digestible diet, enemas if indicated, and other symptomatic measures aimed to conserve strength until the infection runs its course are in order.

Immunization against spotted fever may be effected through administration of vaccine. However, its use should preferably be limited to areas where the disease is highly endemic and the fatality rate high. Two types of vaccine are available, one prepared from infected ticks and one from the infected chick embryos (hen's eggs).



## MURINE TYPHUS

## ROCKY MOUNTAIN SPOTTED FEVER

Fever	Rises rapidly after onset by steps reaching peaks of 104° F., or higher by end of first week. Subsides by rapid lysis by 14th day. May drop to normal at times.
Rash	Small reddish macules varying in size, many visible only by close bedside inspection, slightly elevated, more pronounced during febrile peaks.  <i>Rash first appears over lower chest, abdomen and back, spreading later to soles and palms. Rarely includes the face.</i>  Rash begins about 5th day, subsides before the 10th day— <i>entirely gone before convalescence.</i>
Blood picture	Normal at first, tending toward leukopenia as disease advances.
History	Usually history of rats in home or place of occupation of patient. Sometimes definite history of flea bite.

Rises rapidly after onset, reaching peak of 106° F., or higher in second week. Ranges from 102 to 106 or higher in very toxic and fatal cases. Subsides by lysis during third or fourth week.
Macular, rose-red in color. Macules darker than those of typhus and can be plainly seen 10 to 15 feet away. Macules increase in size as disease progresses, becoming darker, even purpuric and confluent at times, or necrotic in severe cases.  <i>Rash first appears on the extremities (wrists and ankles) and extends rapidly to the body (back, buttocks and chest). Often includes face and scalp.</i>  Rash begins between the 2nd and 4th day and <i>persists throughout the febrile period and well into convalescence</i> , becoming brownish in color with age.
Normal at first, tending toward leukocytosis as disease advances.
Either definite history of tick bite or of exposure to ordinary dog ticks.

Both are effective immunizing agents. Vaccination consists of three subcutaneous injections of 1 cc. at intervals of seven to ten days. For children under ten years of age, the dosage is 0.5 cc. Persons constantly exposed to ticks should be revaccinated each year thereafter with one injection of 1 cc. Local reactions such as redness, swelling, tenderness and itching may develop. Occasionally there is observed mild fever, headache and malaise for twenty-four to forty-eight hours. An itching urticarial rash has been noted in some instances. Anaphylactic reactions of a serious nature have been reported and, as both types of vaccine contain protein, these complications should be borne in mind, especially with individuals known to be hypersensitive. Chicken embryo vaccine should not be given to persons allergic to egg protein. There is no evidence indicating that vaccination subsequent to bite by an infected tick will in any way influence a resulting infection.

Probably the most practical method of prevention is avoidance of known infested areas during the tick season, and care in the removal of any ticks which may become attached to the body. Those who visit such areas should frequently examine clothing and body for ticks. Usually they do not become attached to the host at once but crawl around for several hours. Frequent examination may lead to the discovery and removal of the ticks before they have had the opportunity for biting. They should be removed

with a small forceps (eyebrow tweezers will do) or a small piece of paper or cotton.

E. J. SUNKES,

*Assistant Director of Laboratories,  
Georgia Department of Public Health.*

## HOSPITALS IN THE MAKING

Formation of a Federal Hospital Council and an advisory committee to assist Surgeon General Thomas Parran of the U. S. Public Health Service in the administration of the Hospital Survey and Construction Act has been announced by Federal Security Administrator Watson B. Miller. The first meeting of these groups was held September 17 and 18 in the U. S. Public Health Service Building, Washington, D. C.

The purpose of the meeting, Mr. Miller said, was to formulate plans for administration of the recently enacted Hill-Burton Act which embodied one important feature of the President's national health program. Mr. Miller characterized this Act as "an epoch in the development of health legislation designed to meet serious and widespread needs," explaining that, "for the first time we are embarked upon a national policy of planning and constructing hospitals and health centers to meet the health needs of all the people. For the first time we are creating new institutes not on a sporadic unplanned basis, but on the basis of a long-range, carefully thought out program, integrated to the role that our hospitals and health centers must play in the future."

To carry out this objective Congress has authorized the appropriation of \$3,000,000 for surveys and planning and \$75,000,000 for 5 years annually for construction. Of these sums, \$2,350,000 for surveys and planning has been appropriated.

A state will be eligible to receive construction funds after it has developed a state plan for the construction of needed hospital facilities, based on a statewide survey of existing facilities and existing needs.

## GEORGIA STATE NURSES' ASSOCIATION

### THE NEW FIELD FOR NURSES

ADELAIDE LAND STEWART, R.N.

*President-Elect, G. A. I. N.,*

*Director, A. A. I. N.*

A comparatively new field, and one with great future opportunities for nurses, is in industry. Industrial nurses constitute the largest group of professional workers rendering health and medical services on a full-time basis, thus industrial nursing ranks as one of the most important components of the industrial and community health programs.

Fifty years ago there were only a few opportunities for industrial nurses to take jobs in factories; today we have approximately 15,000 nurses working in industrial plants. One cannot help but wonder at this tremendous increase of nurses that have entered industry in such a relatively short time. How can we account for it? We will admit, of course, that since the beginning of the war the number of nurses recruited into industry has been greater than ever before. However, this is not the primary reason for this tremendous increase. The basic reason is that the pioneer nurses in industry were able to visualize the magnitude and importance of the industrial field. They took advantage of their opportunities and have been able to prove to management, to a remarkable extent, that nursing service is a profitable investment, that a good medical setup plays an important role in the reduction of absenteeism, and thereby production costs, and that a good nurse is a necessity which industry cannot afford to be without.

Industrial nursing has made rapid progress in the past few years and there can be no doubt that the compensation laws were and still are one of the basic reasons for the rapid development of industrial health. The role of the industrial nurse in giving emergency care in a small, ill-equipped first-aid station has changed to the broader aspects of service in a modern well-equipped station, dispensary or hospital. Industrial nursing in the South is virtually a new field, much of the development having been brought about since 1941. For example, the first few industrial nurses in Georgia plants were employed during World War I. These nurses worked alone and developed their programs as well as they could with their knowledge of general nursing principles. Since 1941 the number of industrial nurses in Georgia alone has expanded from approximately 65 to over 200.

The duties and responsibilities of the industrial nurse differ widely because of the varying occupational needs and health requirements of the individual plants she is employed in, so that

the standardization which characterizes other specialized nursing service is largely lacking in industrial nursing. In general, however, a pattern has evolved which can be used as a practical guide in the establishment or improvement of an industrial nursing service.

### *Industrial Nursing Combines the Activities of Hospital Nursing and Public Health Nursing*

Nurses work under supervision and standing written orders as a guide for the nursing care of the injured. She gives wise counsel concerning illnesses and furnishes emergency care while the worker is on the job. She assists the doctor and is ever on the alert for medical hazards and works toward maintaining good health and mental stability among the workers. Today more than ever before the industrial nurse must be able to assume more responsibility. She must be calm and collected at all times, revealing sympathetic interest in the workers' problems and disclosing real consideration while giving nursing care. She should have knowledge of the plant operations and processes and be acquainted with the required physical capacity for each operation. The industrial nurse is the liaison official through whom management and worker are constantly brought into a mutual friendly relationship. She is largely the key to the situation, but changed conditions make it necessary to "make a new key" nearly every day.

The industrial nurses of Georgia, being a wide awake group of intelligent, well-trained young women, have found that to meet their daily problems scientifically they must prepare themselves more thoroughly through industrial nursing courses, professional organizations and literature published concerning their particular field of nursing. It cannot be stressed enough the importance of nurses maintaining their professional affiliations, and be interested in keeping up with advances in their profession. The affiliations desirable are alumnae, district, state and American nurses associations, the local industrial nurses group and the state and American Association of Industrial Nurses. Individual nurses may have the guidance of the industrial consultants offered by the Georgia State Department of Public Health and the U. S. Public Health Service.

At present the Georgia nurses are planning attendance of institutes offered by the Tuberculosis Association of Georgia and the State Health Department. In an attempt to further the advanced education of the Georgia industrial nurses, the State Association is working in conjunction with the University System of Georgia to include industrial nursing in their newly formed health courses.



## DOCTOR NATHANIEL BROWNSON

(Continued from page 293)

Attainder of 1781 by which all of his property was confiscated. In the last named article he is listed as a delegate to the Continental Congress,<sup>17</sup> but this was incorrect.

After his term as Governor, he was returned from Glynn County as a delegate to the Legislature. He was declared ineligible on the grounds that he already held an office, but he again qualified.<sup>18</sup> He resigned shortly to receive the appointment of Justice for Glynn, Liberty and Camden counties<sup>19</sup> and in 1783 was elected delegate to the Continental Congress "in the room of Joseph Clay, resigned."<sup>20</sup> In 1784 he applied for land grants and bounty, and a dispute arose as to how much he was entitled.<sup>21</sup> Both he and Dr. William Read had received their bounties of 100 guineas and 1,000 acres as officers of the line, but each had applied for additional grants on the basis of the bounty granted to returned refugees, and the so-called citizen's bounty. After considerable discussion their applications were denied—a rather curious reaction since the Legislature had granted Count d'Estaing 25,000 acres and similar large tracts were given to other patriots.<sup>22</sup> While Georgia had almost unlimited land to grant, efforts were made to limit the holding to 1,000 acres and to eliminate fraud. Both Brownson and Mathews were requested to make an accurate return of the men actually serving in the militia in order to assure that grants went according to the law. In 1784, under the influence of Lyman Hall and John Houston, the Legislature granted to a Board of Trustees, of which Brownson was one, 40,000 acres for use in the establishment of a university<sup>23</sup> and thus laid the foundation for our present University System. While this early period was comparatively free from fraud, the turn of the century was to see the biggest land scandal in American history.

Brownson remained active in Georgia

politics during the formative period in statehood, being Speaker of the House which ratified the Federal Constitution in 1788, and President of the Senate in 1789 and 1791. Among his last political efforts he was commissioned to superintend the building of the Capitol at Louisville, Georgia. He signed the acts which repealed the banishment and confiscation invoked on many Tories, including Dr. Thomas Taylor of Augusta.<sup>24</sup>

Brownson died November 6, 1796, in Liberty County. The brief biography by Jones, while relating a rather pleasing anecdote concerning Mrs. Brownson mentions no children. I am led to believe that he died without issue.

Efforts to trace his early history in Connecticut have been non-productive.

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TULAREMIA, RABBIT-BORNE DISEASE,  
TRANSMITTED BY PHEASANT

Tularemia, usually caused by contact with rabbits, was acquired by a patient after eating pheasant, according to two doctors writing in the August 31st issue of *The Journal of the American Medical Association*.

N. J. Kursban, M.D., and Lee Foshay, M.D., from the Department of Medicine, the Jewish Hospital, and the Department of Bacteriology, University of Cincinnati College of Medicine, and the Cincinnati General Hospital, state that the only other known instance of transmission from the pheasant was reported in 1936.

A person suffering from tularemia develops swellings of the skin with the formation of abscesses, swelling of the lymph glands and small spots of infection in the internal organs.

The authors point out that the "predominant role of wild rabbits and hares as sources of human tularemia has focused attention so narrowly on these animals that the possibility of transmission from other sources may be overlooked."

## NEWS ITEMS

## COUNCIL MEETING

## MEDICAL ASSOCIATION OF GEORGIA

Atlanta, September 22, 1946

1. The Council was called to order by the chairman, Dr. W. F. Reavis.

2. The roll call by the Secretary, Dr. Edgar Shanks, showed the following present: Dr. W. F. Reavis, Waycross; Dr. R. H. Chaney, Augusta; Dr. S. P. Kenyon, Dawson; Dr. Edgar Shanks, Atlanta; Dr. Chas. T. Brown, Guyton; Dr. C. H. Watt, Thomasville; Dr. W. C. Elliott, Cuthbert; Dr. Marion C. Pruitt, Atlanta; Dr. Spencer A. Kirkland, Atlanta; Dr. Enoch Callaway, LaGrange; Dr. H. D. Allen, Jr., Milledgeville; Dr. W. H. Perkinson, Marietta; Dr. D. Lloyd Wood, Dalton; Dr. C. B. Lord, Jefferson; Dr. D. H. Garrison, Clarkesville; Dr. H. L. Cheves, Union Point and Dr. J. Victor Roule, Augusta. Also present were two guests, Dr. J. A. McAllister, Atlanta, and Dr. Walter C. Earle, Atlanta, both representatives of the Veterans Administration.

3. The chairman asked Drs. McAllister and Earle to present their proposals regarding a plan to facilitate the examinations and other medical services for veterans. After full discussion by all present, the Council assembled in executive session and approved for the time being—until June 30, 1947—the fee schedule used now by the South Carolina Medical Association, except that a physical examination shall include a urinalysis and the fee shall be \$7.50, and that the administrative costs shall be eliminated for the Georgia plan. Dr. Shanks was authorized by the Council to sign for the Association any agreement made with the Veterans' Administration.

4. Other fee schedules were discussed, particularly that for the Georgia workmen's compensation cases. Disposition of this problem will be made later, so that the new fees charged for medical and surgical work can commence January 1, 1947. Drs. Callaway, Elliott and Chaney were appointed a sub-committee to agree on adjustments of fees, after which the Executive Committee of the Association will act and then transmit to the proper authorities the wishes of the Medical Association of Georgia regarding such fees.

5. Drs. Chaney, Shanks, Roule and Pruitt discussed the meeting place for the Association in 1947, with particular reference to the facilities in Augusta for holding the 1947 meeting. After due explanations, and questions from other members of the Council, it was voted to hold the meeting at the Bon Air Hotel, Augusta.

6. Dr. Shanks discussed the increased costs for printing The Journal, for medical defense and for other activities of the Association, but stated that the dues and other income had so far met the expenses. The dues were set for \$7 for 1947.

7. Dr. Chaney discussed some of the plans of the Woman's Auxiliary regarding its efforts to help the profession, particularly in the preparation and distribution of literature. After some discussion regarding public policy and legislation and the functions of the Committee on Public Policy and Legislation of the Medical Association of Georgia, the Council agreed that all such material should be first submitted to the Committee on Public Policy and Legislation of the Medical Association of Georgia to avoid conflicting opinions and conflicting activities.

8. Adjournment.

EDGAR D. SHANKS, M.D.  
*Secretary-Treasurer.*

The annual scientific meeting of the Georgia Pediatric Society was held Oct. 10, 1946, in Atlanta.

Dr. Carl C. Aven, Atlanta, announces the return from military service of Dr. Joe S. Cruise, formerly of Alto, and their association for the practice of medicine, at suite 212 Medical Arts Building, Atlanta.

Dr. Lee Bivings, Atlanta, announces the association of Dr. Joseph H. Patterson in the practice of pediatrics, 20 Fourth Street, N. W., Atlanta.

Dr. John Bush, Columbus, has completed his special training in gynecology and surgery at Mayo Clinic, Rochester, Minn., and has returned to Columbus.

Dr. Alston Callahan, formerly of Atlanta and the Army of the United States, professor of ophthalmology, Medical College of Alabama, Birmingham, announces the opening of his office, 903 South Twentieth Street, Birmingham, Ala. Practice limited to diseases of the eye.

Dr. Hal McCluney Davison, Dr. C. Raymond Arp and Dr. John S. Atwater, Atlanta, announce their association for the practice of medicine, 207 Doctors Building, 478 Peachtree Street, N. E., Atlanta. Internal medicine and allergy.

The graduating class of the Crawford W. Long Hospital School of Nursing, Atlanta, held its graduating exercises in the auditorium of the Nurses' Home, Atlanta, Sept. 20, 1946.

Dr. Goodrich C. White, president of Emory University, announces the appointment of new faculty members. Named to posts in the school of medicine were: Dr. Stephen W. Gray, assistant professor of anatomy; Dr. Paul Rieth, associate in surgery; Dr. Thomas S. Harbin, instructor in clinical ophthalmology; Dr. Cyrus H. Stoner, instructor in clinical ophthalmology; Dr. John R. McCain, instructor in obstetrics and gynecology; Dr. John B. Hickam, assistant in medicine; and Dr. Rafe Banks, assistant in anatomy.

Dr. M. A. Fort, Bainbridge, health commissioner, has been assigned local registrar of Decatur County. Dr. Fort, a resident of Decatur County for many years, and who has rendered many public services during his term as local health officer, succeeds his late wife, Mrs. Pearl Quinney Fort, who held the position as county registrar since her appointment in September, 1945.

Dr. Wadley R. Glenn, Atlanta, announces the opening of his offices, 30 Prescott Street, N. E., Atlanta. Practice limited to surgery.

The Georgia Baptist Hospital staff dinner meeting was held in the Nurses' Home Dining Room and Sheffield Clinic, Atlanta, Sept. 17, 1946.

Dr. R. Kennon Hancock, Atlanta, announces the opening of his office at suite 312 Medical Arts Building, Atlanta. Practice limited to obstetrics and gynecology.

Dr. Stephens Lafayette Harp, Cochran, announces the opening of his office at Cochran for the practice of medicine. Dr. Harp served with the Medical Corps of the United States Navy for 28 months, the major portion of this time being spent on Okinawa. Prior to his service with the Navy, he was connected with the U. S. Public Health Service, Brunswick, the State Health Department, Greenville, and also practiced medicine at Marshallville.

Dr. Lamont Henry, Atlanta, announces the removal of his offices to 30 Prescott Street, N. E., Atlanta. Practice limited to internal medicine.

Dr. John M. Hulsey, Jr., formerly of Gainesville, announces his return from the Medical Corps of the United States Army and his association with Dr. H. H. Lancaster for the practice of medicine at New Holland and Gainesville.

Dr. Charles S. Jones, Atlanta, announces the opening of his office for the practice of surgery, Medical Arts Building, Atlanta.

Dr. R. B. Gilbert and Dr. Samuel E. Kaplan, Greenville, announce the association of Dr. J. Render Turner with the Gilbert-Kaplan Clinic, Greenville.



Dr. Arthur D. Little, Thomasville, announces the association of Dr. Frank A. Little, 407 Upchurch Building, Thomasville. Practice limited to general surgery and radium therapy.

Dr. Marcus Mashburn, Sr., Cumming, reports that a 25-room wing is soon to be added to the Mary-Alice Clinic, at present a 10-bed hospital. His sons, Dr. Marcus Mashburn, Jr., and Dr. Jim S. Mashburn, recently joined the staff after being discharged from the U. S. Army.

Dr. John D. Martin, Jr., Atlanta, has opened offices for the practice of surgery at Emory University Hospital.

Dr. A. G. Pinkston, formerly of Ludowici, announces his release from the armed forces and the opening of offices for the practice of medicine at Glennville.

The Southeastern Allergy Association will hold its second annual meeting, January 18-19, 1947 at the Biltmore Hotel, Atlanta. Hotel reservations should be made directly with the hotel. Dr. Hal McCluney Davison, Atlanta, president; Dr. Warrick Thomas, Richmond, Va.; vice-president; Dr. Katherine Baylis MacLinnis, Columbia, S. C., secretary-treasurer.

Dr. David Henry Poer, Atlanta, was recently awarded the Army Commendation Ribbon in recognition of his outstanding services as Chief of the Surgical Service in Baker General Hospital, Martinsburg, W. Va. Before his discharge, Dr. Poer was a colonel in the Medical Corps.

Dr. Floyd R. Sanders, Decatur, was recently released from the Medical Corps of the U. S. Navy and is now associated with Dr. G. A. Duncan, Decatur, for the practice of medicine.

Dr. Walter D. Spearman, Social Circle, has re-entered the Medical Corps and is stationed at Fort Jackson, Columbia, S. C. He had been practicing medicine at Social Circle since receiving his honorable discharge some months ago. He retained his rank as colonel.

The fifth annual meeting of the American Academy of Dermatology and Syphilology is scheduled for Cleveland, Ohio, December 7-12, 1946, it is announced by Dr. Earl D. Osborne, 471 Delaware Ave., Buffalo, N. Y., secretary of the Academy. This will be the first meeting of the group since 1941, and it is expected to attract more than 1000 members.

Special lectures will be held on precancerous epidermis, biologic effects of atomic energy, capillary circulation of the skin, dermatologic manifestations of blood dyscrasias, chemosurgical treatment of external cancer, pathology of disseminated erythematous lupus, and "Is Nationalization of the American Economy Unavoidable?" There will be special courses given in dermatopathology and other subjects.

Dr. Carl C. Aven, Atlanta, was elected governor of the College of Chest Physicians for the State of Georgia at the annual meeting of the American College of Chest Physicians held at San Francisco, June 27-30, 1946.

The Seventh District Medical Society of Georgia met at the High School Auditorium, Calhoun, September 25. The members of the Gordon County Medical Society were hosts. Program: Invocation by Rev. Y. A. Oliver, pastor, First Methodist Church, Calhoun. Address of Welcome, Dr. R. D. Walter, Calhoun, president of the Gordon County Medical Society. Scientific papers: "Indications and Methods of Inducing Labor," Drs. C. B. Upshaw and Robert H. Gillespie, Atlanta; discussion led by Dr. W. H. Perkinson, Marietta, and Dr. Trammell Starr, Dalton. "Carbohydrate Metabolism," Dr. Warren Gilbert, Rome; discussion led by Dr. J. E. Billings, Calhoun and Dr. W. B. Quillian, Jr., Cartersville. "The Diagnosis of the Acute Surgical Abdomen," Dr. Ralph

Johnson, Rome; discussion by Dr. J. T. McCall, Sr., Rome, and Dr. W. D. Hall, Calhoun. "The Use of Biologicals in Pediatrics," Dr. Roger W. Dickson, Atlanta; discussion by Dr. R. C. Maddox, Rome, and Dr. R. W. Fowler, Marietta. Officers: President, Dr. W. C. Mitchell, Smyrna; President-elect, Dr. D. Lloyd Wood, Dalton; Secretary-Treasurer, Dr. Inman Smith, Rome; Councilor, Dr. W. H. Perkinson, Marietta. Committee on arrangements: Dr. J. E. Billings, chairman, Dr. W. D. Hall and Dr. R. D. Walter, all of Calhoun.

The Woman's Auxiliary to the Seventh District Medical Society of Georgia held its meeting at the Hotel Rooker, Calhoun, September 25. Program: Welcome, Mrs. R. D. Walter, Calhoun; response, Mrs. Muriel Haygood, Marietta; reading of minutes, reports from county auxiliaries, new business. Address, "Objectives for This Year," Mrs. Bruce Schaefer, Toccoa. Officers: Mrs. W. C. Mitchell, Smyrna, district manager and Mrs. W. D. Hall, Calhoun, secretary.

Dr. John Venable, a former instructor at Emory University, has been named city-county health commissioner, and Dr. J. H. Duncan, Gainesville, is to be sanitarian of the city of Dalton and Whitfield County. Both are at Vanderbilt University, Nashville, Tenn., for three months' training in their respective fields prior to assuming work at Dalton.

Dr. J. P. Ward, Brooks-Colquitt health officer, announces he will be at Quitman Thursdays and Fridays of each week and anyone wishing to see him on any matter may reach him by leaving a message with the local health department.

Dr. R. K. Winston, Tifton, after five years' service in the Medical Corps, has re-opened his office in the McLeod-O'Neal Building, Tifton. Practice limited to the diseases of the eye, ear, nose and throat.

Dr. Joe D. Woodail, Lumpkin, recently released after more than three years service in the U. S. Army Air corps, has opened offices over Thompson's Pharmacy, Lumpkin, for the practice of medicine and surgery.

Dr. James A. Wood, Macon, a former colonel in the U. S. Army Medical Corps, has accepted a position in the department of medicine and surgery at the Macon sub-regional office of the Veterans Administration, Macon.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, October 3. Program: Case report, "Congenital Dislocation of Hips," Dr. H. Walker Jernigan. Clinical talk, "Medical and Surgical Problems in a Japanese Prison Camp," Dr. Alfred A. Weinstein. Paper, "Laboratory Aids in the Diagnosis of Liver Diseases," Dr. E. Van Buren.

The Georgia Chapter of the American College of Surgeons will meet at the Academy of Medicine, Atlanta, October 31. Dinner will be served at 6:30 P.M. Dr. Frank H. Lahey, Boston, Mass., will be the speaker of the evening.

Dr. B. Russell Burke, Atlanta, is attending for several weeks a graduate course at the Lempert Institute of Otology, New York City.

Dr. S. Ross Brown, Atlanta, recently attended the joint session of the International Anesthesia Research Society and International College of Anesthetists, New York City.

American Board of Obstetrics and Gynecology Examinations. The next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 7, 1947, at 2:00 P.M. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the secretary, Dr. Paul Titus, 1015 High-

land Building, Pittsburgh 6, Pa., by November 1, 1946. Candidates in military service are requested to keep the secretary's office closely informed of changes of address.

Dr. J. A. Thrash, Columbus, county health officer, recently had as his guests Dr. Augusto Morales Asua, Bolivian doctor-surgeon, Dr. George Kiourtsis and Dr. Constantine J. Prouskas, Athens, Greece. The physicians expressed the opinion that Columbus "has one of the best sanitation programs in the State."

Southern Medical Association, Fortieth Annual Meeting, Miami, Florida, Monday through Thursday, November, 4-7, 1946. Hotel reservations will be made directly with the hotel of one's choice: McAllister, Columbus, Colonial, Everglades and Alcazar.

The Fifth District Medical Society and the Georgia Chapter of the American College of Surgeons will meet at the Academy of Medicine, Atlanta, October 31. Dr. Frank H. Lahey of Boston, Mass., will speak on, "The Management of Malignancy of the Stomach, Duodenum and Jejunum." Officers of the Fifth District Medical Society are: Dr. Evert A. Bancker, Atlanta, president, and Dr. L. Minor Blackford, Atlanta, secretary-treasurer.

### OBITUARY

*Dr. Herschel Baker Bray, Sr.*, aged 51, prominent physician at Wrightsville, where he had practiced medicine for 23 years, died July 2, 1946. Dr. Bray was born in Johnson County, the son of the late Charles Thomas Bray and Mrs. Dealphia Stokes Bray. He graduated from Emory University School of Medicine in 1922 and interned at Grady Hospital, Atlanta. He was a member of the Laurens County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association, a World War I veteran and a member of the Methodist Church. Noted for his medical acumen, his generosity and humanitarianism, it has been said since his demise that no other man in the county has been and will continue to be so deeply and sincerely missed. Survivors include the widow, Mrs. Mary Edna Jennings Bray, one son, Herschel Baker Bray, Jr., and one daughter, Dee Anne Bray, all of Wrightsville. Funeral services were held from the First Methodist Church, with the Rev. J. F. Snell, Rev. W. H. Reid and Rev. W. R. Foster, officiating. Burial was in Westview Cemetery, Wrightsville.

*Dr. Webb Conn*, aged 67, Brunswick, died following a heart attack, Aug. 21, 1946. Dr. Conn was a native of Conn's Creek section of Cherokee County. He moved to Canton, where he lived until he entered the Atlanta College of Physicians and Surgeons, where he was graduated in 1902. He practiced medicine in Canton, Rome, Griffin, and from there he moved to Brunswick where he practiced medicine a number of years. He was a member of the Glynn County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association. Surviving are his wife, the former Miss Martha Kilby of Canton, one brother, W. L. Conn, and one sister, Mrs. F. L. Richards, Acworth. Funeral services were held at the First Baptist Church, Brunswick.

*Dr. Eugene Rollin Corson*, aged 91, pioneer roentgenologist and prominent physician, died at his residence, 10 West Jones Street, Savannah, June 10, 1946. Dr. Corson was born July 20, 1855 at Washington, D. C., the son of the late Hiram Corson and Caroline Rollin of Paris, France. He was a graduate of Cornell, of Hahnemann Medical College, Philadelphia, and the Southern Medical College, Atlanta; then took postgraduate work in medicine at Vienna, Austria. He began the practice of medicine at Savannah in 1879.

Dr. Corson, by his papers and articles on x-rays, became internationally known, and established some of the first theories on x-ray studies. Besides continuing his work as an x-ray pioneer, he published many papers

on obstetrics and surgery. He was also interested in natural history, philosophy, the comparative study of religions and physical research.

He was a member of the Georgia Medical Society, the Medical Association of Georgia, the Association of American Anatomists, American Electro-Therapeutic Association, American Medical Association, and American Roentgen Ray Society. On Oct. 22, 1937 the Georgia Medical Society gave a large banquet in his honor and presented him with an illuminated testimonial in recognition of his work.

In 1885 he married Mrs. Belle O'Driscoll, who died in 1886. He married a second time in September, 1894, to Cora Wirt Baker, of New Orleans, who survives him; also by three children, Mrs. George N. Coad, Eugene Rollin Corson, Jr., and Mrs. Paul J. Cavanaugh, New York. Private funeral services were held at the residence, 10 West Jones Street, Savannah, the Rev. R. E. Charles, rector of St. Johns Episcopal Church, officiating. His ashes were buried in the family plot of the City Cemetery, Savannah.

*Dr. William Meigs Fambrough*, aged 74, Bostwick, prominent Morgan County citizen and physician died Aug. 22, 1946, at St. Joseph's Infirmary, Atlanta. Dr. Fambrough was a native of Oconee County, the son of the late Jesse and Delila Freeman Fambrough. He graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1904. For the past 45 years Dr. Fambrough had practiced medicine in Morgan and surrounding counties. He was always faithful to those in need of his services and was highly regarded by everyone who knew him.

He is survived by his widow, Mrs. Claude Davenport Fambrough; three daughters, Mrs. J. H. Malcolm and Mrs. Irene Tillman, both of Bostwick, and Mrs. H. J. Whitaker, Miami, Fla.; two brothers, L. D. Fambrough, Atlanta, and Emmett Fambrough, Bradenton, Fla.; and four grandchildren. Funeral services were held at the Bostwick Baptist Church, with the Rev. Harold Carnes, Rev. E. A. Caldwell and Rev. Thomas Fowler officiating. Burial was in the Bostwick Cemetery.

*Dr. John Alexander Hembree*, aged 67, Pearson physician, died at his home following a heart attack, Sept. 15, 1946. Dr. Hembree was born at Roswell Aug. 24, 1879. He graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1905, and took a post-graduate course at Johns Hopkins, Baltimore. He had practiced medicine at Culloden, Danville, Macon, Jeffersonville, going finally into the CCC service as a reserve officer. He was a First Lieutenant in the Medical Corps until the beginning of World War II, when he was called into the Army as a Captain. He was released from active duty on account of his health and began the practice of medicine at Pearson, where he established the Hembree Clinic. He was a member of the Coffee County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association; also a member of the Pearson Baptist Church, the American Legion, the Pearson Lions Club, and the Masonic Lodge.

Survivors include his wife, Mrs. Eleanor Stroud Hembree, Pearson; one daughter, Mrs. D. Hughes Taylor, Macon; one grandson, Daniel Hughes Taylor, Jr., Macon; two brothers and two sisters. Funeral services were held at the chapel of Hart's Mortuary, Macon, with Dr. Carl G. Campbell, pastor of the Vineville Baptist Church, Macon, officiating. Burial was in Riverside Cemetery, Macon.

Dr. George A. Semken, well known in Atlanta and who delivered the Abner W. Calhoun address at the annual session of the Medical Association of Georgia in Augusta several years ago, died Sept. 17, 1946, at New York City.



# *THE JOURNAL* OF THE *MEDICAL ASSOCIATION OF GEORGIA*

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## OCCUPATIONAL DERMATITIS

CLARENCE SHAW, M.D.  
*Chattanooga, Tenn.*

The incidence of occupational dermatitis in this country has been rapidly increasing due to the expansion of our industrial program which involves the conversion of peacetime factories into ordnance and munition plants, and the employment of many new workers in hazardous occupations, where there has been no time to install safety devices or educate either the management or the workers regarding the dangers involved. Furthermore, new chemicals and processes are being employed about which we know very little. Excluding actual accidents, industrial dermatitis accounts for at least 60 per cent of all occupational disease. The skin being that portion of the body which comes in contact with external irritants, bears the brunt of these insults which are most frequently chemicals which injure the skin or sensitize it so that an allergic reaction appears.

By definition, an industrial dermatitis is a disease of the skin caused by an exposure incident to industry. Since industrial workers, like all individuals, may develop a dermatitis from contacts not related to their occupation, every effort must be made to determine the industrial or nonindustrial origin of their conditions. It is well recognized that dissimilar irritants may produce an identical looking eruption. For example, the characteristics of a dermatitis due to

T.N.T. do not differ in appearance from a dermatitis due to the insecticide the worker uses in his victory garden.

Occupational dermatitis may be nonallergic or allergic in type. Nonallergic dermatitis is caused by common irritants or substances which, when applied to the skin in sufficient concentration for a sufficient length of time, will produce a dermatitis in all individuals. Thus if you apply a strong solution of acid or alkali or soap or solvent to any person's skin for long enough time it will produce a dermatitis. In allergic dermatitis the substance which produces the dermatitis is innocuous to the majority of individuals. The mechanism of production of this reaction is not known but the skin, after one or more contacts with the specific substance, acquires a hypersensitivity which is shared by the entire epidermis. People are not born allergic to a substance with which they come in contact, but acquire their sensitivity through exposure to the offending substance. Some individuals become sensitized and yet with repeated exposure become "hardened," so to speak, to the extent they are able to tolerate further contact with the substance without showing manifestations. We see an example of that in the T.N.T. industry where all workers can handle T.N.T. without the appearance of a dermatitis for the first two or three weeks, after which time a certain percentage of them develop a sensitization dermatitis. If these men are kept on the job handling T.N.T. a goodly proportion of them will become "hardened" or resistant so that they can continue to handle the T.N.T. without further appearance of an eruption.

Two procedures are necessary for the investigation of a case of allergic industrial dermatitis. The first is an accurate and detailed history which should include information regarding industrial and nonindustrial exposures, the length of employment on the present job and the incidence of dermatitis among his fellow workers. It is important to know whether the site of the greatest intensity of the dermatitis corresponds to the points of maximum contact with the suspected irritant. The taking of an intelligent history implies that the physician must have a working knowledge of the actual manufacturing processes involved was the case of a woman employe who unable to evaluate the situation. This type of information may only be gained by a visit to the factory concerned.

With the history at hand and a knowledge of the nature of the patient's employment, clues are obtained for utilizing the second procedure, which is the performance of patch tests. This valuable test for studying contact allergies is easily applied and with experience readily interpreted. It is imperative, however, that certain precautions be observed in the technic and interpretation of the test. Obviously one would not test with a strong concentration of hydrochloric acid or undiluted lysol. Standard concentrations for testing various substances have been determined and can be found in texts and articles dealing with this subject. Furthermore, it is hazardous to perform a patch test even with weak dilutions in the presence of a severe dermatitis, since it is liable to produce a marked flare-up of the eruption. If the technic has been correct, a positive reaction indicates that the individual is hypersensitive to that substance but it does not necessarily prove that the substance is the cause of the patient's eruption. The results of the test must be correlated with the history. Nor does a negative reaction prove

that the suspected irritant is not the causative factor. Friction, heat, perspiration, photosensitization and other factors existing under actual working conditions cannot be reproduced in the technic of the patch test. Here again the history is most important.

Practically every industry has its associated skin hazards. A few problems encountered in this community will be briefly discussed.

Shortly after a local ordnance works began production a large number of employes developed an inflammatory dermatitis involving primarily the hands, arms, and face. The eruption resembled closely a dermatophytosis of the hands with deep sago grain-like vesicles. It appeared on those men handling the T.N.T. in the final stages of its processing, such as in the drying and weighing rooms, the nail house where it is packed and those who worked around the waste water and acids which contain traces of T.N.T. in solution. All of the affected men showed a positive patch test within 24 hours, the patch being a saturated solution of T.N.T. in acetone. Where the eruption was not too severe men were encouraged to remain on the job, since it had been shown that many of them would become "hardened." They were required to take daily showers, wear fresh uniforms and gloves laundered and provided by the company, and to apply a protective ointment. Local treatment consisted of boric acid or magnesium sulfate wet dressings followed by a bland cream, such as boric acid ointment. In many cases it was possible to retain trained personnel on the job, which was obviously an important manpower problem.

In a large woolen mill a considerable number of employes developed an eruption involving the exposed areas of the skin and, in some instances, the entire body. Most of the affected individuals worked in the wash house and fulling mills where the cloth is



soaked in a strong alkaline solution containing among other things soda ash, pine oil and soap. The high degree of alkalinity of this mixture was responsible for defatting the workers' skins so that they developed a dermatitis. These men were provided with protective sleeves and aprons and given protective ointments, since when the incidence of loss of man hours in this industry has been materially lessened.

A factory which manufactured water and gasoline containers for the armed forces reported an outbreak of dermatitis among the workers. An inspection of the plant revealed that shortly before the onset of the trouble a new chemical-chromic acid was utilized. In some instances the workers' clothing became so saturated with the chemical that it dropped from their bodies, as was the case of a woman employe who suddenly found herself standing without a skirt. This substance was a primary irritant; that is, it would irritate anyone's skin if allowed to remain in contact for a sufficient length of time. The situation was corrected by substituting a less irritating chemical for the chromic acid.

A minor outbreak of dermatitis occurred in a plant which manufactures marine boilers. After careful investigation it was noted that the only workers affected were those who came in contact with a certain insulating material used in the boilers. Patch tests revealed that these men were all sensitive to the insulating material. It was necessary in this case to transfer these men to another part of the plant where they would have no contact with the offending substance. In another plant which made waterproof containers for airplanes it was found that several cases of dermatitis were due to an insulating material used for their manufacture.

During the past summer about 50 employes of a local boiler plant reported with

a dermatitis on the covered portion of the skin. These men worked in every part of the factory and had in common the fact they all perspired excessively, wore dirty clothes for as long as a week without change and bathed infrequently. The diagnosis in these cases was miliaria, or heat rash, which was not directly related to their work and hence could not be classified as an occupational dermatitis.

In this connection it is worth pointing out that the one single measure most valuable in the prevention of occupational dermatoses is cleanliness of the worker. Daily baths with mild soaps, daily change of clothing, a clean locker and shower room and a clean plant will do more to prevent dermatitis than anything else. Indeed, the chief virtue of the so-called protective ointments is that the employe will always wash it off from his skin before he goes home, thus removing not only the ointment but the offending substances which might cause a dermatitis.

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#### PENICILLIN IN OIL AND WAX

A sterile suspension of calcium penicillin in a mixture of highly refined peanut or sesame oil and white wax, U. S. P., or yellow wax, U. S. P.

*Actions and Uses.*—Penicillin suspended in oil and wax is slowly absorbed following intramuscular injection. After the injection of 1.0 cc. of a mixture containing 300,000 units of penicillin per cubic centimeter significant blood concentrations of penicillin have been observed for from twelve to twenty-four hours. Injection of lower concentrations decreases the duration of effective penicillin blood levels, 100,000 units giving a measurable blood level for approximately eight hours and 200,000 units being effective for about twelve hours.

Penicillin in oil and wax may be used for all the conditions for which penicillin dissolved in saline solution is used. The principal difference between the two lies in the frequency of injection; saline solutions must be injected once every two to three hours, whereas oil and wax mixtures require injection only every twelve to twenty-four hours.

*Dosage.*—At least 300,000 units every twenty-four hours should be administered, either as a single dose or in two doses twelve hours apart. For severe infections two 300,000 unit doses twelve hours apart may be necessary. For the treatment of gonorrhea, one injection of 300,000 units of penicillin in oil and wax appears to be sufficient for the majority of cases. If the subjective symptoms do not subside rapidly, a second injection of 300,000 units should be given twenty-four hours after the first.

## DISORDERS FREQUENTLY FOUND WHEN EXAMINING THE CHEST

J. A. REDFEARN, M.D.

*Albany*

Cardiac disorders and pulmonary tuberculosis, because of their importance, have been discussed frequently before this society, which has helped us remember them when patients relate their histories. Too little emphasis has been made on some other important chest conditions, resulting often in overlooking or failing to remember them. The latter are essential in making a diagnosis.

### *Sighing*

Dr. Paul White says that "There are only three fundamental disorders of respiration; namely, (1) dyspnea, that is difficult breathing; (2) cardiac asthma, and (3) Cheyne-Stokes breathing. Rapid breathing (tachypnea), slow breathing (bradypnea), and sighing respiration are not directly related to heart disease, although they are sometimes so misinterpreted, particularly the last named."

I find that many patients who are addicted to sighing call it shortness of breath and occasionally a heart examination is requested, giving it as the chief complaint. The only treatment needed is to stop it. It is entirely functional.

### *Aortic Aneurysms*

Aortic aneurysms are rather frequent among our people and are often overlooked on physical examination alone. The most reliable evidence, of course, is found through x-ray. Dyspnea, dysphagia, cough, hoarseness, and pain in the presence of a positive Kahn or history of syphilis call for investigation.

Here a word of caution may be advis-

able, for everything that looks like an aortic aneurysm is not one. This is clearly demonstrated in certain chest films.

### *Emphysema*

Emphysema is a condition characterized by chronic distention or rupture of some of the alveoli (air sacs) of the lungs. Asthma, whooping cough, and chronic bronchitis are frequent causes. Anything that puts undue pressure on the larynx, bronchi, or bronchioles may hinder expiration, which is normally more difficult than inhalation due to the action of the diaphragm and intercostal muscles. Deformities of the bony chest, such as Paget's disease, acromegaly, and damaged intervertebral disks, etc., may be direct causes of emphysema.

The onset of emphysema is insidious. Puffiness and dyspnea upon exertion, with perhaps some cyanosis, are usually the early symptoms, but cyanosis may soon become marked. These symptoms are exaggerated in the winter. The anteroposterior diameter of the chest gives the barrel shape. There is kyphosis of the upper dorsal spine with elevation of shoulders; the intercostal spaces are widened; the sternum is prominent; the apical impulse cannot be seen but pulsation in the epigastrium is prominent. Some of these symptoms are prominent in heart disease, so do not be too hasty to diagnose heart disease. Unfortunately, this is not an infrequent error in diagnosis.

Emphysema cannot be cured, but the patient may receive relief through the use of ephedrine and phenobarbital, and the use of an abdominal belt as devised by Alexander and Kountz, or Kerr.

### *Bronchiectasis*

Bronchiectasis is a chronic progressive disease of the bronchi or bronchioles, producing dilatation and chronic cough. It may be congenital or acquired, and is seen about as often as pulmonary tuberculosis but is much less frequently recognized. It has



too long been dismissed in childhood diagnoses where it generally has its beginning as bronchitis and a cough prescription was given, which is not only unfair but is wrong. Doubtless a doctor who follows such a plan gives great comfort and hope for the time being, but such treatment will not last. The parents of that child, or the patient, will learn that cure could have been had with little risk through a lobectomy as now performed by the skilled thoracic surgeon.

The damage to the bronchial wall is due to infection which, if not congenital, may have followed one of the acute infectious diseases, notably whooping cough and measles. Pneumonia and influenza also may cause the disease. Sinus infections have been referred to as a frequent direct cause of bronchiectasis, but more recently a symposium on bronchiectasis in *The Journal of the American College of Chest Physicians* noted agreement that when the two conditions existed together the bronchiectasis preceded the paranasal sinusitis.

A persistent cough at any age which is difficult to control, and frequent flare-ups of colds in the absence of tuberculosis, should lead to a study of the possibility of the presence of bronchiectasis. Sputum examinations may reveal molds, fungi, and spirilli which are likely secondary invaders, so do not stop here and administer iodides. The instillation of iodized oil will determine whether bronchiectasis is present or not.

The cough is worse after lying down or getting up, due to change of posture. There may be only a small amount of sputum, or in severe cases as much as a liter a day. Sometimes there is noted a foul odor but this is not generally present. Hemoptysis is present in about 50 per cent of cases. Despite the severe cough, the patient will generally look well. The films demonstrate the irregular, mottled saccular densities in both lower lobes. Note particularly the flat-

tening of the domes of the diaphragm and hyperventilation of the upper lung fields.

### Conclusions

In conclusion, permit me to urge you to fix in your minds these disorders in differential diagnoses of chest conditions.

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## SOME INTERESTING ALLERGIC CASES

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EUGENIA C. JONES, M.D.

MASON I. LOWANCE, M.D.

WARREN B. MATTHEWS, M.D.

*Atlanta*

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In this paper a deliberate departure is being made from one of our well established scientific customs. We know that at this meeting, as at many others, a great many papers will be presented which are devoted to reviewing the literature and analyzing statistics based on the work of other individuals. Our object in this paper is not to review the work of others but rather to present some observations which proved both interesting and thought-provoking to us. None of the following cases is extremely unusual and similar cases have been previously presented and discussed in the medical literature. However, they all present problems which occur so frequently that there is not an individual in the room, including ourselves, who has not at some time been misled by the dilemmas which this group of cases presents. With these remarks in mind, we have completely omitted the review of the literature regarding this subject and will proceed at once to discussion of the clinical cases.

### REPORTS OF CASES

*Case 1* is that of a man aged 64, who was seen in May 1943 because of a generalized urticaria. The patient stated that he had had a similar attack of urticaria in March 1942, at which time he had some teeth extracted, but the urticaria continued. He had been hospitalized at this time after about six weeks of urticaria, treated by

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elimination diets, et cetera, but showed no improvement until he was placed on a strictly milk diet. After this the urticaria disappeared within three to four days' time.

When seen in 1943 the patient exhibited at first a mild urticaria which subsequently became generalized and severe. At this time his physical examination was essentially normal with the exception of the urticaria and the presence of marked pyorrhea and dental infection. The patient was advised to continue with his dental work and to have the balance of his teeth extracted if necessary. He was placed on a milk diet but did not show improvement. He was maintained on this diet with a gradual addition of other foods, including rice, potatoes, string beans and beets. Various medications were given at the office, including sodium thiosulphate intravenously, adrenalin hypodermically, calcium chloride intravenously, potassium gluconate orally, holadin capsules, and ephedrine and amylal capsules, all without relief. In July the patient finally consented to have the indicated dental work done and had all of the remaining teeth removed. When next seen, about two weeks later, the urticaria had almost completely disappeared. A recent report from this patient states that since removal of these teeth he has had only occasional urticaria which has been quite mild and really no major disturbance at all since having had his teeth extracted.

This case is interesting from the standpoint of illustrating the production of urticaria secondary to the presence of infection. All of the usual medications were used in this particular instance without avail, until finally the source of infection was removed, when recovery occurred promptly. The fact that he still continues to have minor disturbances illustrates the well known fact that a truly allergic individual will remain so the rest of his life. His improvement with the removal of the source of infection illustrated the importance which intrinsic contributing factors may have in producing disturbance in an allergic individual.

Case 2 is a woman aged 39, who has been under treatment for hay fever and asthma for a period of about ten years. While this individual is definitely sensitive to house dust, fall pollens, cat hair, and some of the other inhalants, she has never shown really satisfactory response to the use of extracts, even though she improved somewhat on their use. Some recent work has suggested that oral administration of a mixture of herbs might prove of benefit in such individuals. One type of such preparation has been used with good results in several instances and this particular patient represents one of the best responses to this form of treatment.<sup>1</sup>

This patient always had extreme hay fever and asthma during the fall pollen season, but for the past two years has been maintained on this oral preparation and has had practically no fall hay fever. At the end of each fall pollen season, however, she has usually had a recurrence of one or two moderately severe asthmatic attacks. In other words, the oral medication has helped to some extent but not as completely as we would hope. The interesting point is that it has really produced some improvement in an individual who has otherwise been quite hard to treat. If preparations of this type can be perfected to the point of producing similar improvement in large numbers of patients, then of course the tremendous saving in time will be obvious. Response in this and in one other patient was 75 per cent better than on ragweed extract hypodermically.

Case 3. This patient when first seen was a child aged 12 years, whose chief complaint was generalized eczema. Incidentally in history-taking, the fact was brought out that she had some mild hay fever during the summer months and had occasional mild asthmatic attacks. Skin

tests were done principally with the idea of eliminating any foods as sources of the eczema. As occurs in so many similar cases, skin tests showed very few foods to which marked sensitivity was demonstrable. However, the inhalants and pollens showed more definite reaction. This child was placed on an elimination diet beginning with the foods to which she was least sensitive and gradually adding those to which she was more sensitive. She was finally restored to a full diet.

Meanwhile extracts to control the hay fever and asthma were begun, these consisting of house dust, timothy and ragweed. Not only has she had no recurrence of hay fever or asthma, but in addition the eczema began to improve promptly as soon as extracts began to be administered. Within about a month after she had reached and been held regularly on her maintenance dose of extract, the eczema disappeared entirely and has not recurred. It was our feeling that dietary factors were of minor importance in this individual, but that they, combined with her other allergic disturbances, produced a sum total which resulted in eczema. As soon as a large proportion of her allergic reaction, in the form of asthma and hay fever, was removed by administration of extract, the eczema also showed satisfactory improvement. In this particular case the factor of puberty must also be borne in mind but a search of the literature will no doubt reveal similar cases in which this additional upsetting factor does not enter.

Case 4 presents a problem which is frequently confusing as well as difficult to handle. This patient was a woman, aged 52, who was in the menopausal age and who had had cessation of menstruation in August 1942, three years before she was seen by us. Since that time she had had no hot flashes and no other marked menopausal disturbance with the exception of the fact that examinations since menopause have shown an elevation of her blood pressure above normal. However, she continued without much disturbance except the elevation of blood pressure until 1944, at which time she began to have asthma. She was skin tested in another city, showed some positive reactions, and was treated with extracts as a true allergic individual. Her response was poor and when first seen by us she was in an extreme state, with blood pressure readings around 192/110, and asthma which for a few days was completely uncontrollable. Electrocardiograms at this time verified some cardiac damage with coronary insufficiency. The patient was helped somewhat by the use of sodium iodide and by aminophyllin. However, when she was placed on digitalis her improvement was dramatic and immediate. The patient was finally discharged from the hospital on a maintenance dose of digitalis and with very, very little asthma. She continued to use potassium iodide regularly, and adrenalin as necessary, to control minor attacks of asthma, but to our knowledge, in the four months since her discharge from the hospital, she has had no recurrence of severe asthma.

This patient gave practically no history of previous allergic disturbances. She did mention eczema occurring after vaccination as a child but her description of this was a little uncertain and this could have been secondary to an infection. She had never had hay fever or urticaria. The fact that her hypertension and her asthma coincided somewhat in the time of onset should suggest that the cardiac factor was much too important to be overlooked. Cases similar to this are seen very frequently in middle-aged individuals and much is to be learned from observation of one such case.

Case 5 is presented to call to mind some of the interesting points in connection with the heredity of allergic disturbances. This was a woman aged 30, who was quite sensitive to ragweed. For most of the previous year extracts had been omitted because of pregnancy and because of the fact that with her previous pregnancy she had had no hay fever. Extracts were begun in May and at that time she was nursing her infant. The patient soon reported that on the days she received the hay

1. The preparation is prepared by the Illinois Herb Company, Chicago, and consists of a tea which is prepared in the following manner:

To two cups of boiling water add one heaping teaspoonful of wild plum bark, one level teaspoonful each of coltsfoot and mullin, and let steep for twenty minutes.

Take two cups of the tea each day, beginning in May and taking it through October.



fever extract she noted, after the following nursing, the baby sneezed extremely. This suggests, first, that the infant had inherited the mother's allergic tendency; and second, that the antigen must have been excreted into the milk in order to produce this reaction in the infant. In most allergic individuals we can demonstrate some familial tendency to this type of abnormality, but nowhere do we see it more clearly illustrated than in such a case as this. Of course, a non-allergic child would not have shown such a reaction.

*Case 6.* This was a man aged 25, who had been under care for some time for hay fever and asthma. He had received extracts with some success and had used ephedrine and amylal capsules, as well as adrenalin hypodermically, with no unfavorable reaction. On one occasion when he was given 1 cc. of adrenalin in oil intramuscularly, the response was prompt and dramatic. The patient showed all the signs of circulatory collapse and of heart failure. The pulse rate dropped to about 66. Electrocardiogram taken at that time showed prolongation of the PR interval to 0.2 of a second and QRS deformities suggestive of an intraventricular block. The patient subsequently recovered satisfactorily. We mention this only to point out the possible danger in the use of this particular preparation. While this may have represented an individual sensitivity to the oil in which the adrenalin in oil is suspended, it seems more likely that it represents a sudden, complete absorption of a large dose of adrenalin, with subsequent drastic circulatory reaction. Previous injections of the identical make of adrenalin in oil gave no reaction in this individual. While adrenalin in oil is a widely used preparation and reactions of this type are not frequently encountered, still the very possibility of their occurrence has made us very cautious in the use of this drug.

*Case 7.* Many recent reports in the literature state that there is no sensitivity and practically no unfavorable individual reaction to the use of penicillin. These reports are contradicted somewhat by some authors who state that urticaria does occur in some instances. We have had occasion to observe two or three of these which, while not serious, were nevertheless extremely annoying to the patient. One recently occurred in an individual recovering from an appendectomy and in whom there had been some question of a mild peritonitis. Sulfadiazine had been instilled into the wound and, post-operatively, penicillin therapy was begun immediately. After about three days on penicillin therapy the temperature rose above what would be expected for the post-operative period and the patient began to develop urticaria. This progressed rapidly and became generalized and extreme. Even after the discontinuance of the penicillin, the urticaria remained marked for many days and the patient's postoperative course was much stormier on this account than it would have been otherwise. There is a tendency to overuse penicillin just as there has been a tendency to overuse sulfathiazole and the related drugs. The possibility of extremely unpleasant reactions to penicillin must be borne in mind. These also could be extremely dangerous in individuals who happen to be a little more sensitive than this particular one.

In summary, cases illustrating the following points have been presented:

1. Urticaria, with infection as a precipitating factor.
2. Non-specific therapy in the treatment of hay fever.
3. Eczema as a result of combined food and inhalation type allergies.
4. Cardiac asthma, combined with

bronchial asthma, in one individual.

5. Transmission of hay fever to nursing infant.
6. Unfavorable reaction to use of adrenalin in oil in an allergic individual.
7. An extreme urticaria and eczema from the use of penicillin.

#### DISCUSSION OF PAPER BY DRS. JONES, LOWANCE AND MATTHEWS

DR. J. A. REDFEARN (Albany): "Some Interesting Allergic Cases" naturally brings to minds of listeners such similar cases found in our practices. One of particular interest to me emphasizes the importance of tests for foods in the adult, as well as for reactions to other foreign proteins. It used to be said that testing for food allergies in the adults was not near so important as in children. This may be still true but the occasional case will prove the exception, illustrated by the following:

A negro woman aged 40 was referred in September, 1944, by Dr. W. S. Cook, of Albany, for examination before doing a hysterectomy for the removal of a uterine fibroid. The patient was hypertensive with a systolic pressure range from 210 to 220 and diastolic readings of 120 to 130. It was decided that a rest period was advisable before any operative procedure might be undertaken. The patient wandered away and was not seen again for three months when she stated that she had lost 25 pounds due to bronchial asthma, which had existed for about two months, her first experience with it. At this time she had had static attacks day and night for a period of three weeks, and was unable to lie down. The usual treatment gave some relief but the attacks continued.

It was suggested that she come in for skin tests, which she did, and proved negative to the usual tests, amounting to 203, except house dust and cashew nut. She was advised not to eat this nut which she had been eating along with pecans in large quantities, because her husband, who worked at a local shelling plant, had been bringing home a supply. She had eaten largely of cashew nut during the three weeks of her illness. She stated that if cashew nuts caused it, the others might, so she would not eat any nuts. It was explained that peanuts, pecans and several others were all right, but she steadfastly refused to eat any nuts. The attack of asthma was promptly relieved and she has not touched another cashew nut to date and has not had any symptoms whatsoever of bronchial asthma. The 25 pounds she lost were regained in about two months. She appears well and healthy at this time. She still carries a blood pressure of 220/120, and her surgeon has not yet made up his mind to do a hysterectomy.

The Medical Association of Georgia will hold its next annual meeting at the Bon Air Hotel, Augusta, April 22-25, 1947.

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

## AN EFFECTIVE CONTRACEPTIVE: PHENYLMERCURIC ACETATE JELLY

AMEY CHAPPELL, M.D.  
*Atlanta*

It has been stated that a good contraceptive must be safe; it must be effective in preventing live spermatozoa from reaching the uterus; it must be easy to use; it must be cheap and obtainable without difficulty. It must not cause sterility and it must be aesthetically acceptable.<sup>1</sup> A jelly containing phenylmercuric acetate in a concentration of 0.02 per cent as its active spermaticidal agent seems to meet these requirements.

Eastman<sup>2</sup> has shown that although it is absorbed and excreted by the kidneys, the amount is so small that it may be disregarded and that no vaginal irritation results from its use in quantities even larger than those which would be ordinarily used. Its effectiveness in killing spermatozoa in less than one minute's contact has also been demonstrated.

While some clinics have advised its use with diaphragms and not alone, we have found it effective without the mechanical aid of the diaphragm. It has had not the slightest tendency to produce sterility, and many cases of vaginitis and, at times, non-specific cervicitis, have seemed improved after its use. To most couples, and most particularly those in the lower income group, it is not aesthetically unacceptable when used alone. There are a few who object to it on the basis that it is "messy." For these few, some other method should be selected which emphasizes again that there is no single method of contraception which is best for all. The choice should always be

made after a careful consideration of individual needs.

The jelly has been dispensed in collapsible metal tubes with a syringe-like plastic applicator having a capacity of about six cubic centimeters. The patient has been instructed to inject slightly less than one applicatorful into the vagina before intercourse, rotating the applicator so that the jelly will not be deposited in one area. She is advised not to take a douche at any time. If one is to be used, six hours should elapse before it is taken. The jelly which has been used is a light amber-colored, semitransparent one which is only faintly perfumed. Two patients have complained of vaginal irritation following its use. The validity of one of these was questioned since the patient had objected to the jelly when it was originally dispensed. Otherwise we have had no complaints following its use.

Observation of this jelly has been carried on in the contraceptive clinic of Grady Hospital in Atlanta. This clinic has been operating since January, 1938. In seven years 828 patients made 1,320 visits. They were all Negroes. Most of them attended the clinic only once. Our clientele has not been cooperative. They came in the first place for several reasons: curiosity, the suggestion of a friend, and occasionally because of medical advice. These patients come from the lowest social strata, and have low incomes. They are suspicious of birth control information, particularly when it is offered by their white neighbors. Doubtless many of them suspect that race extinction may be its aim. They are fearful that in some way it may affect their health or their virility, and usually have a deep conviction that it is sinful to interfere with God's plan. Education is gradually breaking down these prejudices, but among those of little learning, and these are our patients, only the overwhelming burden of poverty and many children bring them for advice. Those in

<sup>1</sup>Read before the Medical Association of Georgia, Macon, May 8, 1946.

<sup>2</sup>From the Department of Obstetrics and Gynecology, Emory University School of Medicine.



the most desperate straits continue to use the prescribed contraceptive when it can be afforded. Others do not.

Since the opening of the clinic several methods of contraception have been advised—diaphragms with a jelly, foam powder, and jelly alone. For the past two and one-half years the only jelly used has contained phenylmercuric acetate. For this time the majority of patients have been given jelly alone and the results have been more satisfactory than with the other methods. It is simple enough to be understood by all but the most feeble-minded for whom sterilization is most suitable. We continue to dispense diaphragms, but the fitting is time-consuming and often impossible due to the perineal relaxation which follows multiparity. The primary reason for fitting them at all at the present is that the house staff may gain experience. Whatever method has been advised, it has usually not been continued for very long. The patients often discard it altogether early, or use it intermittently and blame it for subsequent pregnancies. Many excuses have been offered for these failures: too much trouble is involved, it is too hard to get supplies, discomfort is associated with its use, or the husband objects. Most often, perhaps, after a time of successful contraceptive practice, the wife wants to convince herself that she can have a baby if she wants one.

In a seven year period 1,320 tubes of jelly, 140 diaphragms, and 495 boxes of foam powder were dispensed. Pregnancies have occurred during the use of all, but it is certain that there have been fewer with the jelly. It has been impossible to keep accurate records because of the unreliability and poor memories of the patients.

We are sure of several things. A contraceptive jelly containing phenylmercuric acetate when used alone is non-toxic; a doctor is not required to dispense it; it will not

cause sterility, and it prevents pregnancy in a large majority of cases. This is a method of contraception which can easily be made available to people in rural areas. The jelly may be dispensed by a public health nurse or perhaps by the county demonstration agent. It is a simple method for a doctor to prescribe in his own office, or to give to clinic patients where time must be conserved.

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### TREATMENT OF BARTHOLIN ABSCESS (OR CYST)

EDGAR H. GREENE, M.D.

*Atlanta*

A swollen vulvovaginal gland is usually classified as either an abscess or cyst. While these two conditions predominate, we should remember that swelling in this area may be a hernia coming from the inguinal region above or from within the vagina; moreover, it may be a cyst of the vaginal wall.

In elderly women, especially those within or past the menopause presenting an enlargement of a vulvovaginal gland, the possibility of malignancy always should be borne in mind. At this time, however, discussion will be limited to Bartholin's cyst and abscess.

If the enlargement is an abscess, we find the usual signs and symptoms—rapid onset, heat, redness, pain and swelling. This condition is generally unilateral, but not infrequently both sides are involved.

Formerly vulvovaginal abscess was almost universally ascribed to an invasion by the gonococcus. We know now that an abscess in this area may be caused by the colon bacillus and/or mixed organisms.

The gonococcus continues to head the list of causative factors.

If a fluctuant lump has been present for several days and has no redness and no pain on manipulation and gentle pressure, the swelling is quite likely to be a cyst. Trauma is often responsible for this condition which frequently produces an occlusion of the orifice of the duct with resultant encapsulation of the fluid secreted by the gland. Enlarged glands are sometimes seen in the first week or ten days postpartum.

Microscopic examination of cyst or abscess fluid should be made in each case for the purpose of accuracy in diagnosis.

The usual treatment for abscess or cyst is either (1) incision and drainage or (2) total extirpation. Either procedure requires hospitalization and anesthesia with a subsequent period of incapacity of four or more days' duration. It is possible, of course, to incise and drain a vulvovaginal abscess or cyst in the office, but such procedure may be fraught with considerable inconvenience to all concerned. Simple cyst may be relieved by locating the external orifice and inserting a small probe. The occluded duct may open and drain spontaneously following application of heat or Sitz baths.

The object of this presentation is to bring to your attention a simple office procedure that has proved very satisfactory in handling cases of either abscess or cyst regardless of the type of organism encountered. One treatment is usually sufficient although it is sometimes necessary to repeat the procedure.

In 21 patients treated in private practice during the past year, two needed additional treatment, with good result following the second and third treatments. Another patient had recurrent attacks and had been drained twice while in a distant city. Both of her Bartholin glands were sclerosed and failed to respond to treatment. She was hospitalized and the glands were extirpated.

None of the others has reported recurrence of their trouble.

Equipment usually used includes:

- 1 needle, size 18—2½ or 3 inches long, sterile.
- 3 5 c.c. glass syringes, sterile.
- 20 per cent sulfathiazole suspension.
- ST-37 or ceepryn, aqueous solution, 1:1000.

*Technic.* A thin layer of absorbent cotton is saturated with pontocaine. The cotton is then applied to the fluctuant lump and left for ten minutes. The cotton is then removed and a small cotton applicator with phenol in the tip is applied to the dependent spot on the abscess wall. This phenolized spot should not be larger than the end of a match stick. The large needle, attached to a 5 c.c. syringe, is quickly inserted into the cyst, taking care not to penetrate the floor of the abscess or cyst.

The contents are withdrawn into the syringe and measured. The pus and syringe are discarded, but the needle is held in situ until the operation is finished.

A second syringe containing ST-37 or ceepryn is attached to the needle. The solution is injected into the cavity and withdrawn. This should be repeated (by discarding used solution and adding fresh solution) until the cavity is well irrigated and emptied and the second syringe discarded.

The third syringe containing 20 per cent sulfathiazole suspension is attached to the needle and an amount equal to two-thirds the quantity of the original cyst contents is injected, i.e., if 3 c.c. of pus were removed, then 2 c.c. of sulfathiazole suspension should be injected. The needle is withdrawn, a vulva pad applied and the patient is allowed to leave the office and return to her usual duties.

It is not necessary to occlude the opening made by the needle as only two or three drops of the heavy suspension will escape.

No subsequent treatment is necessary, as a rule, and the vulva has a fairly normal appearance in about ten to fourteen days.

Several years ago Dr. W. S. Dorough,



of Atlanta, used a procedure which was adopted by me and prompted the use of the sulfathiazole suspension when the preparation was offered to the profession. Dr. Dorough's technic was similar to what I have described in so far as the aspiration and irrigation of the cyst are concerned. He also left a portion of the irrigating antiseptic solution (ST-37) in the cavity. Many, if not all, of the cases in which I used this procedure recurred and later went to surgery.

I have been unable to find any report of the use of sulfathiazole suspension, 20 per cent, being used in cases as here described. It is believed that this procedure, while rather new, may be of practical interest to some of you at this time, and is therefore presented at this early stage rather than defer the report until a larger series of cases has been accumulated.

### Summary

1. A simple office procedure for the treatment of Bartholin's abscess or cyst is described. A single treatment is usually sufficient for cure, and that by aspirating the cyst, irrigating the cavity and instilling a 20 per cent suspension of sulfathiazole for retention in the cavity.
2. The patient is not incapacitated during treatment, and the expense is minimal.
3. Surgical procedure in recurrences is rarely but sometimes necessary.
4. No untoward results were encountered during the performance of this procedure in any case that I observed.

### DISCUSSION OF PAPERS OF DR. AMEY CHAPPELL AND DR. EDGAR H. GREENE

DR. JOHN T. PERSALL, JR. (Augusta): This is a very interesting paper of Dr. Chappell's. For a fair evaluation of this jelly we must compare various types against each other, for it must be remembered that in general practice one out of every five couples is sterile anyway. This is not true, of course, in the clinic type of patients.

I wish to thank Dr. Greene for this interesting treatise on a new treatment of an old complaint, Bartholin's abscess. I have not used sulfathiazole suspension

instillation following aspiration of pus and irrigation of the infected gland but have used the technic of aspiration of pus, irrigation with ST-37 and instillation into the gland of 7.5 per cent mercurochrome with varying degrees of success. Many cases eventually recurred and extirpation of the gland was necessary.

I believe it to be the duty of every physician to perform in his office those procedures which may be properly done and also his duty to hospitalize those patients who may not be properly treated in the office. Hence, I heartily agree that those cases requiring excision of the gland be hospitalized and a general anesthetic be given, for although within itself a simple operation it is often a tedious operation to remove the entire gland, which must be done to prevent recurrence of abscess formation and also frequently there may be much hemorrhage due to the vascularity of the adjacent tissues. Continuous suture and obliteration of the cavity gives hemostasis, and on hemostasis may depend the success of the operation. Incision medially through the vaginal mucosa is preferable to the approach through the skin, laterally.

Either abscess or cyst of Bartholin's gland is not always diagnosed with ease. In a differential diagnosis we must always eliminate the following: perirectal abscess, hydrocele of the round ligament, inguinal hernia containing an ovary, hernia of omentum or bowel, abscess or cyst of the gland with a hernia, lipoma or other tumors of the labium majus, and last but not least common, a vaginal cyst. Particularly is it quite common to find a cyst of the vestigial Gartner's duct in the distal end as it passes down the lateral vaginal wall to the hymen.

I should like to commend the author for perfecting this simple office procedure in treating Bartholin's abscess so that most patients may remain ambulatory without work stoppage and hospital beds thereby conserved for other cases.

DR. J. M. BARNETT (Albany): I don't want the young lady to be neglected. She gave a very interesting paper. Many contraceptives could be used to advantage, but the class of people seeking this advice would not take the time to use this convenience as a prophylactic, therefore a more radical method should be used if the results are to be 100 per cent. There is no perfect contraceptive. In modern day surgery there is no need of resorting to little useless and dirty methods of controlling conception. Go in and tie your tubes and come out in three minutes and come out of the hospital in four days. You have finished your job.

The doctor, in the case of the Bartholin gland, gave us a most interesting point that I wish to call to your attention, and that is the diagnosis. It is a minor procedure, and in the hands of the young surgeon he is likely to get in serious trouble if he doesn't make his diagnosis.

And one thing I want to call your attention to that neither of them mentioned in connection with complication following excision or incision, and that is hemorrhage, and whenever you go into the labia or portions of the pudenda, look out for hemorrhage. It is nothing to think lightly of. There are many ways to control it, but the best way to control it is don't have it. That is the complication in handling the Bartholin gland. Don't touch it unless you expect trouble, and then when you meet trouble meet it with *tactus eruditus*.

DR. EDGAR H. GREENE (Atlanta): I would like, in closing my discussion, to say a few words regarding Dr. Chappell's paper, for I have noticed her work for some time. She has been very faithful in conducting the experimental work that she has reported here and all of you that have had any familiarity at all with handling Negro women in a large clinic know that she has had a task that is almost insurmountable. My experience with this type of patient at Grady Hospital Clinic was very discouraging when we attempted such procedure as she has carried out. This class of people, in par-

ticular, should be properly instructed in the use of contraceptives. I might also say that Dr. Chappell is conducting at the Good Samaritan Clinic, in Atlanta, a sterility clinic where she is attempting to determine the cause of sterility in a great many women who come to that clinic. The work is outstanding, although she has not, I believe, as yet made a report.

I appreciated very much the discussion of my paper, particularly in regard to what Dr. Barnett had to say about hemorrhage. I made no particular mention of it due to the fact that my paper was limited to an office procedure and, as he stated, if you make the diagnosis and are careful in your technic, you won't have any hemorrhage in doing this simple procedure. However, if hemorrhage occurs you have a most annoying complication. Fortunately, I haven't encountered it while carrying out the non-surgical technic as described in the paper. Postoperative hemorrhage following extirpation of the gland is, of course, a real problem. The way to avert it is to be sure and ligate the vessels before the patient leaves the operating room, just as Dr. Persall pointed out in his discussion.

I believe if you try this simple procedure that you will be pleased with it. My results have been quite satisfactory, and I think anything we can do to keep these young women on their feet and eliminate the cost of hospitalization and other expense is well worth while. Moreover, we will have done a great deal towards assisting women who need it at a time of considerable pain and discomfort.

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## A REPORT ON THE PROGRESS OF PUBLIC HEALTH IN GEORGIA

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*Atlanta*

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The quarter century from 1920 through 1945 was one of extraordinary achievement in public health in Georgia. Within this period the average duration of human life has been extended by 13.9 years—more than six months for every year in the period.

The death rate from all causes declined from 11.1 in 1920 to 8.6 in 1945, a decrease of 22.5 per cent. Improvement has been notable with respect to diseases which respond favorably to better sanitation and other public health procedures. The death rate from malaria was reduced from 19.3 to 0.8 per 100,000 population; from typhoid fever, 19.0 to 0.9; and from diphtheria, 13.8 to 2.2.

Perhaps the most vivid proof of the success of the public health movement has been the striking decline in tuberculosis mortality

in Georgia during the past three and a half decades. This is a comparatively short time in which to witness a fundamental change in health conditions. However, at the beginning of the century tuberculosis stood first in the list of causes of death and was an especial menace to the lives of young adults. Today it ranks eighth in numerical importance as a cause of death in the general population and is declining steadily. There is no reason why it should not follow into the limbo of almost forgotten diseases in Georgia. Since 1920 tuberculosis has been reduced from 81.6 deaths per 100,000 population to 34.4 in 1945. During the twenty-five years under consideration tuberculosis was responsible for the death of 50,065 Georgians.

It is unnecessary to point to the obvious truth that in this period it is not the people who have changed but their environment which has been so modified as to make the State a safer place in which to live. We have passed through two great wars which, though fought in foreign lands, were not without serious repercussions on the lives of those who were not called overseas; into this period fell the worst epidemic in the memory of the present generation—the influenza scourge of 1918; and the century experienced one of the severest economic depressions in our history. Yet in the face of these handicaps we have witnessed the marvelous development which has added more than a decade to the average duration of life.

This fortunate change in environment has been brought about by a systematic and continuous campaign of effort on the part of the medical and public health professions. To them the people owe a debt for their ceaseless activities in the face of the many difficulties which have beset the professions.

The development of the preventive services furnished, however, has been unevenly distributed throughout the State. Complete



geographic coverage by full-time local health departments, although a basic need, would not be sufficient to enable us to take full advantage of the possibilities of further advances in the control of disease.

Passive maintenance of present health standards is not enough. In the years ahead aggressively the task of improving the people's health must be pursued. Beginning immediately and in the next few years, it is planned to expand and intensify all preventive services. As you know, plans and money are available for every community, in every part of the State, to have a minimum basic public health organization. These must be staffed with well trained personnel to deal with the precise and complicated tasks of public health.

The only hindrance to a statewide system of local health organizations is the scarcity of physicians and other public health personnel. There is also a dearth of medical facilities, such as hospitals, laboratories, sanatoriums, etc. After all medical and public health personnel possible are released from the armed forces there will still be a shortage. Before the war the 67 medical schools in the United States produced about 5,000 new physicians annually. During the war the national income rose from about 70 to more than 200 billion dollars a year and the demands for medical care increased accordingly. More doctors are urgently needed to meet these demands and to supply public health protection.

Gereology, or the structural changes and diseases incident to old age, is becoming a challenging public health problem. Studies of chronic disease have shown that one out of three individuals over forty years of age has some form of chronic disease. The 1940 census enumerated 3,123,723 inhabitants in Georgia. Of these, 810,305 were over forty years of age. The growth of gereology as a public health problem is indicated by the

fact that in 1850 only 15.1 per cent of the population in Georgia were over forty years of age; in 1890, 17.5 per cent; and in 1940, 25.9 per cent. For the last fifty years this represents an increase in the forty year age group from 128,093 to 810,305 in 1940.

In a comprehensive survey of chronic disease in Massachusetts by Bigelow, Lombard, and Hubert (1933), it was found that four individuals had apoplexy for every death from this cause, 39 were ill with arteriosclerosis for every death, 2 with cancer, 15 with diabetes, 7 with heart disease, 6 with nephritis, and 1,900 with rheumatism for every death. If these findings were translated to Georgia, there would have been the following number of individuals ill with chronic disease in 1940:

Apoplexy .....	12,140
Arteriosclerosis .....	8,736
Cancer .....	3,918
Heart Disease .....	43,232
Nephritis .....	20,088
Rheumatism .....	123,500

Between 1920 and 1945 the death rates in Georgia for typhoid fever, malaria, diphtheria, diarrhea, and dysentery were reduced more than 83.5 per cent; the death rate for tuberculosis, 59.5 per cent; pneumonia, 23.8 per cent. On the other hand, the mortality from all other causes than those mentioned has risen by 8.9 per cent. Today 19.7 per cent of all deaths are due to diseases of the heart, 6 per cent due to other conditions associated with the cardiovascular-renal complex, and 7.8 per cent to cancer.

It is obvious that the solution of these problems is not simple and that no complete solution is possible. The human machine, like all other biologic mechanisms, is wound up to run for a certain number of years. As its primary source of energy is exhausted, death inevitably results. Of the total deaths from heart disease 17.6 per cent occurred at ages 45-54 and 22.8 per cent at ages 55-64; of the total deaths from can-

cer 19 per cent occurred at ages 45-54 and 20.8 per cent at ages 55-64 for the year 1944. This is evidence not of normal but of premature degeneration.

The mortality from diseases of this type is no doubt indirectly influenced by certain standard public health procedures. What is done to control streptocosis and syphilis will be reflected in lower death rates from heart disease years later.

In the main, however, direct control of such maladies as heart disease and cancer depend upon early diagnosis and upon treatment or special regimen of personal hygiene based on that diagnosis—in other words, on good medical care. If ten years of useful life can be gained by postponing a fatal or crippling termination from the age of 60 to the age of 70, the gain is real and significant.

In simple terms, the overall plan of the public health movement is to enable every individual to live a normal span of life in health, happiness, and productivity, to reduce to the minimum the span of terminal or debilitating illness, and to make death as humane as possible. This does not presuppose the elimination of sickness and death, but rather seeks a reasonable control over them. To these ends, gerontology becomes a major public health problem.

The destruction of human life in Georgia by injuries sustained in preventable home, occupational, and public accidents is one of the most deplorable aspects of the mortality record of our State. In 1945 1,870 persons in Georgia were killed by accident of one kind or another. These deaths constituted 6.5 per cent of all persons who died last year and occurred at the rate of 55.9 persons per 100,000 population.

In the coming years many other specific tasks in public health must be undertaken and fulfilled if all the problems are to be met. The gains against preventable disease

and death must be held. The time is coming, however, for attainment of the broad objective—complete health and medical service of high quality in all parts of the State.

In the category of diseases that are in effect the joint responsibility of curative medicine and preventive medicine the least progress has been made and the most progress can be made in the future. A large portion of these are the illnesses that account for the high percentage of rejections by selective service. They are not illnesses that often kill the patient, but illnesses, both physical and mental, that sap his vitality.

It follows from this discussion that to make the greatest progress toward improvement in the general health of the population it is necessary that public health and curative medicine closely join forces. In the past the approach to public health has been on the mass basis. Curative medicine deals primarily with the individual. A combination of these two methods of approach is necessary to reach the disabling illnesses and premature deaths that should be controlled and eliminated. A much more intensive cooperative health education program is needed. The initiation of this is largely the function of public health. Its ultimate objective, optimum health for everyone, is largely a responsibility of the curative medical forces.

Major emphasis in the future should be on optimum health which includes normal growth during infancy, normal efficiency during active life, normal reproduction, normal longevity, and a complete life with the least discomfort and disease, and the greatest amount of well-being. The logical place to start is with the unborn child; the mother should be under good medical supervision from the time she becomes pregnant. All preschool and school children should be under constant medical supervision; all



adults should have periodic health examinations. That objective calls for a comprehensive health education program in every community and adequate medical service. To carry on such a program requires close cooperation of the public health departments, the medical dental and nursing professions, and the hospitals.

The physicians of Georgia are in better position than any other group to realize that our people do not take advantage of present knowledge available for preventing and curing illness. There were 3,542 deaths without medical attendance in 1944. Adequate public health education should have brought many of these people to seek medical care before their health reached the critical stage.

It has been prophesied that "the time will come when illness will be punishable as a crime." In Georgia we are far from that idealistic thinking. However, we can advance sound health practices and face the future in health with keen analytical insight which cuts through loose thinking, pretense, and complacency. To that end I earnestly solicit your assistance.

In concluding a brief discussion of health conditions in Georgia it seems possible to say that the situation has improved satisfactorily under circumstances prevailing since 1920. Numerous major public health problems have now become minor. Other health problems are developing and increasing in intensity. Their solution depends in large measure on closer cooperation between the medical and public health professions.

#### DISCUSSION OF PAPER OF DR. T. F. ABERCROMBIE

DR. WM. R. DANCY (Savannah): We have heard from Dr. Chappell. We have heard from Dr. Abercrombie. The one thought that comes to me along the line of sterilization, prevention of pregnancy and such is, "What are we doing with the criminals in this State relative to enforced sterilization?" If Dr. Abercrombie has any statistics I think it would be interesting to this body to hear something on that subject. California and other states sterilize criminals and also those individuals affected with certain hereditary conditions such as epi-

lepsy. I would ask Dr. Abercrombie to give us a little elucidation along that line.

Savannah chose a way many years ago to develop health measures. The first project that was ever propagated in this State for health measures was drainage in and about Savannah, which occurred along about 1817, as I recall, and a very interesting thing about that on the records of the City of Savannah, which we find in the City Hall, is that \$72,000 was allotted for that project. That \$72,000 represented \$17.00, as the article states, for every man, woman, child and slave.

Recently in Savannah under the guidance of the very efficient health officer there, Dr. C. A. Henderson—and we have a very efficient health department there—a clinic was conducted, or a series of clinics, over a period of almost two months, to eradicate tuberculosis and venereal disease, and we had the cooperation of the medical society, the Woman's Auxiliary and all the local civic organizations in Savannah to back up that project. I have forgotten how many people were examined, but something over 60,000 examinations were made. X-ray examinations were made of the lungs. The blood was examined, Kahn tests made, etc., and the results were very excellent. The best people in Savannah went to the clinic and had x-ray films taken of their lungs and their blood examined as examples to the lower classes. The Health Department of Savannah really deserves to be commended. Columbus, Georgia, has copied Savannah in conducting a similar campaign and this could well be emulated throughout the State of Georgia.

DR. JOHN W. SIMMONS (Brunswick): I could not let this paper go by without some discussion, for several reasons.

First, I was acquainted with Dr. Abercrombie when he was chasing hookworms out of South Georgia for the Rockefeller Foundation. He did the job so well he was hired as the first Glynn County Health Commissioner. Brunswick, Glynn County, was the first county to adopt a health department, under the Ellis Health Law. The whole world knows something about the health program down on your seacoast. Speaking of public health in Georgia, as I told Dr. Abercrombie in Savannah some fourteen years ago, it becomes increasingly difficult as the doctors become lazy about caring for their own communities. He told me at that time there were humble South Georgia doctors vaccinating infants they had delivered and doing practically all the community preventive medicine. At that time they were fussing about the Health Department interfering with general practice. Several doctors in Georgia were giving typhoid vaccine. Somebody told the public it was free at the Board of Health and private vaccination stopped. Now we are having some turn in the other directions in which a great many people are relying upon family doctors to give advice and keep the records straight in getting all these prophylactic measures in effect. When the people of Georgia come to realize the fact that they are guardians, to a certain extent, of their own futures, in regard to infectious diseases, then we will have arrived at millenium of prevention of disease.

I wish to state that in the over-all activities of the Department of Health in Georgia, we can be justly proud. I know of no state that is regaining so rapidly health precedence in the face of all the things that have been said about the South being ignorant, being carefree, being indifferent, being the industrial problem No. 1. We can be extremely proud of the job the State Department of Health is trying to do, both in public health and industrial health and hygiene, through its different departments. I know of no laboratory that can compare with the laboratory that we have and facilities that we have.

Then there is another thing—I shouldn't say this because it may have some political repercussions, but it just will break out—I can't help it to save my life—I think the eleemosynary institutions in Georgia that deal with physical or mental health, that have the unfortunates in those institutions, should be taken out of

politics. I do think that the proper place for them is under the general supervision and direction of a department that has raised standards to the highest level and the Georgia Department of Public Health has qualified for that distinction. I want this done for several reasons—I don't want any of Georgia's facilities for serving its citizens made a political football. Mind you, I am not engaged in the department. I am just pleading that we get the best out of every single facility that the taxpayers pay for, and I believe if we consolidate the departments dealing with all physical and mental health, Georgia and its sons will have taken a long step in advance in improving our reputation throughout the union.

DR. A. J. MOONEY (Statesboro): I want to commend to your attention this fine report that Dr. Abercrombie has given extending back over a period of 25 years. In reading statistics on geriatrics a few years ago I found that we are getting more and more old men and old women who are beyond the age of 70. It is increasing something like the rate of 10 to 15 per cent per year. The medical profession has done its part through hygiene, medication and through diagnosis and treatment as regards these conditions that have heretofore been cutting down the mortality rate. They have raised the age of mankind. We must remember when we get beyond the age of 70 our productive power decreases and it is up to the State of Georgia, through the old age pension and through other allowances and allotments, to take care of these individuals; not all, because some are self-supporting, but there are going to be some that the social and economic powers of the State of Georgia are going to be taxed for.

Dr. Abercrombie also had some other wonderful things in store for us, that with the passing of time, will gradually be revealed to us. I want to commend this paper and give to you a thought relative to what the State will do with these old people.

DR. T. F. ABERCROMBIE (Atlanta): Answering Dr. Dancy's question about the sterility of criminals, we have a sterilization law on the statute books. I am a member of the State Board of Eugenics. The law will only allow us to sterilize people in State institutions. It should be amended and that is one thing you people of the Medical Association of Georgia could well do. The law should be amended so that any one could have voluntary sterilization or the courts could decide whether this was needed or not. We have asked for that authority many times but haven't been given it.

I want to thank you gentlemen for discussing my paper, and say again that we believe in the near future we have great things in store for public health. With the acquisition of Battey Hospital as a tuberculosis treatment facility and with the expanded tuberculosis control program that is being put on throughout the State, the outlook is encouraging. We hope to x-ray everybody in the State of Georgia within five years. With a hospital to place cases located and break the contacts, we believe we can whip tuberculosis within eight or ten years. I look forward with a great deal of confidence to the future of public health in Georgia.

#### AMERICAN ACADEMY OF ALLERGY WILL MEET

The American Academy of Allergy will hold its annual convention at Hotel Pennsylvania, New York City, November 25-27 inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy without payment of registration fee. The program has been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Dr. Horace S. Baldwin, 136 East 64th Street, New York City, prior to November 10th.

## TRIBUTE TO DR. CLEVELAND THOMPSON

EDGAR R. PUND, M.D.

*Augusta*

Ladies and Gentlemen: I would like first to take this occasion to express to the audience the feeling that I have in making this presentation. I feel that it is a privilege to be called upon to do this. I have known Dr. Thompson during my entire medical career. Not only have I known him, but I have admired him as well. That is a strange statement coming from a pathologist who works for a surgeon, but nevertheless it is quite true. I deem it a privilege also because it is so infrequent that one has the opportunity to say to someone's face all of the nice things that he thinks about him, things that we say behind their backs but never do have an opportunity to say to their faces. You can see how privileged I feel in being called upon for this presentation of the Gold Key to our retiring president.

Dr. Thompson, you have been honored many times. Let me state a premise: Honors are not lightly held. That honors remain honors, those who are honored must reflect credit on the position.

In 1909 you were honored by the University of Georgia School of Medicine who granted you the degree of Doctor of Medicine. The faith and wisdom of your teachers and preceptors have been justified by your success. You have demonstrated that success is not dependent upon time and place. With the necessary tools, the incentive for hard work, and the proper ideals, success may be achieved in places of small as well as large population, in locations which are poor as well as wealthy. You have shown that by diligent attendance at medical assemblies and by extensive read-

Address delivered before the Medical Association of Georgia, May 8, 1946.



ing, adequate medical care is possible in places remote from medical centers. You have gained the respect of your colleagues and your patients. You have served the profession well and have repeatedly been elected and appointed to leading positions in medical organizations; president of your local society, president of your district society, councilor of your district and president of the alumni society of your Alma Mater and have served on various committees of this Association. You have gained recognition beyond the borders of the State. Your surgical ability and ethical standards have earned for you a fellowship in the American College of Surgeons. Election to the honorary fraternity of Alpha Omega Alpha is recognition of your leadership.

The premise stated above gained support when three years ago you were selected to lead this Association, at a time when faith in the integrity of its leadership was necessary. How fortunate for the Association that you were in office when circumstances of war necessitated a term of two years! Again you have met the challenge, you have given us leadership at a time when there is the threat of governmental control of medicine. You have emphasized the realization that the science of medicine can be retarded by unwise legislation and the art of medicine hampered by bureaucratic despotism.

In combating this encroachment you have unconsciously injected your own philosophy as a standard about which the profession may rally; a philosophy of morality, fidelity, and honesty. There is only one standard of morality, one is either moral, immoral or amoral. Fidelity cannot be compared. There are no degrees of honesty. These have been the principles of your thoughts, words, and deeds. These qualities are essential for the maintenance of a free profession. They are linked necessarily to the fundamentals of democracy; that is liberty, equality and fraternity. Mor-

ality is necessary for liberty, lest it degenerate into license; fidelity for equality, lest barriers be erected on minor differences; honesty for fraternity, lest we become suspect. This is my interpretation of your philosophy.

Dr. Thompson, your term of office is at end, but your responsibilities are now greater. It is necessary that you remain a leader. The Association will continue to need your counsel. I deem it a privilege to present to you, in the name of the Medical Association of Georgia, the president's key. It is a reward for your accomplishments and a reminder of your responsibilities. You have given to us an example of leadership and a philosophy of life. You have reiterated the appeal of General Washington, "Let us raise a standard to which the wise and the honest can repair." Your philosophy is a worthy standard. Because of your service this honor has become greater for those who follow. You have proved my premise.

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#### IN MEMORIAM

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A. J. MOONEY, M.D.  
*Statesboro*

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In the two years since our last annual meeting, in 1944, the silent, relentless shadow of death has hovered over Georgia and passing so quietly has left in its wake many mounds and shafts to mark the resting place of many medical men—so quietly, so relentlessly has it gathered them unto the bosom of the great common mother that it is only when tabulation has been completed that the number is realized: 140.

Some were permitted by nature to walk this earth, to relieve suffering, to comfort, advise and heal until they had rounded out the three-score years and ten, and beyond, before being called to their eternal rest. For some the silver cord was loosed or the golden bowl broken while yet hardly in the

height of their medical careers. For some the column of life were broken ere their life's work of usefulness had hardly begun.

As the list is called for the last time before being consigned to the Archives of the Association, all of us will recall associations with some of them while they were with us—their attainments; their friendliness; their skill and their fancies.

Here is the honor roll:

- Adams, Charles M., Atlanta, July 3, 1945, aged 74.  
 Ainsworth, Harry, Thomasville, June 19, 1945, aged 68.  
 Allen, George Ollie, Marietta, May 26, 1945, aged 73.  
 Ansley, Hamilton Goss, Decatur, December 16, 1945, aged 43.  
 Aycock, Thomas Rufus, Monroe, Augusta 5, 1944, aged 62.  
 Ballenger, Edgar Garrison, Atlanta, June 1, 1945, aged 68.  
 Banks, John, Hamilton, May 16, 1944, aged 66.  
 Barnett, Stephen Trent, Atlanta, June 27, 1944, aged 73.  
 Barron, Carey A., Kingsland, April 24, 1944, aged 57.  
 Barrow, Craig, Savannah, August 31, 1945, aged 69.  
 Bedingfield, Philip Bartow, Wrightsville, March 15, 1946, aged 84.  
 Birdsong, Henry Walter, Athens, October 10, 1944, aged 61.  
 Borders, William Andrew, Armuchee, January 15, 1945, aged 78.  
 Brannen, Clifford, Atlanta, March 7, 1946, aged 56.  
 Brice, Joseph Theobald, Cumming, October 2, 1944, aged 78.  
 Brinson, Homer Hodges, Brinson, August 25, 1944, aged 66.  
 Brown, Jackson Frank, Macon, August 16, 1943, aged 51.  
 Bruce, Francis Marion, Homerville, December 22, 1945, aged 63.  
 Bullard, Thomas Parker, Palmetto, January 19, 1945, aged 74.  
 Burkhalter, John F., Claxton, May 6, 1945, aged 59.  
 Burns, McIntosh Marcus, Pelham, March 10, 1946, aged 53.  
 Burpee, Claude McKinley, Augusta, December 2, 1944, aged 47.  
 Campbell, Jesse Hope, Commerce, April 14, 1945, aged 55.  
 Carothers, James Bell, Atlanta, January 17, 1945, aged 56.  
 Carson, H. D., Union Point, March 28, 1945, aged 73.  
 Carson, Marcus F., Griffin, November 26, 1944, aged 73.  
 Chandler, Julian H., Swainsboro, August 20, 1945, aged 66.  
 Christian, John E., Duluth, November 11, 1945, aged 78.  
 Cleckley, Marsden Treutlen, Augusta, May 8, 1944, aged 73.  
 Collins, Norman V., Griffin, November 24, 1944, aged 55.  
 Colvard, Thomas Winfrey, Crandall, September 17, 1945, aged 76.  
 Crawford, Claud Burton, Blue Ridge, November 6, 1944, aged 71.  
 Curry, Joel Toy, Macon, June 30, 1945, aged 74.  
 Daniel, Byron, Sardis, November 16, 1945, aged 70.  
 Daniel, Everett, Moultrie, April 22, 1946, aged 74.  
 Darden, Holt, Blakely, January 30, 1946, aged 47.  
 Daves, James Munrow, Blue Ridge, April 22, 1946, aged 86.  
 Davis, John Weyman, Athens, September 18, 1944, aged 42.  
 Downey, Carroll William, Tallapoosa, April 8, 1945, aged 69.  
 Duckett, Alfred Kennon, Blue Ridge, August 18, 1944, aged 33.  
 Eberhardt, Benjamin Franklin, Gillsville, February 21, 1944, aged 75.  
 Elder, Omar F., Atlanta, October 25, 1944, aged 58.  
 Eubanks, George Foster, Atlanta, September 25, 1944, aged 44.  
 Fuqua, Elmer F., Atlanta, January 6, 1945, aged 65.  
 Garland, John Thomas, Macon, February 18, 1945, aged 88.  
 Gibson, Obe C., Macon, April 23, 1945, aged 83.  
 Goodwyn, Henry J., Carrollton, June 24, 1944, aged 70.  
 Goss, Ralph Montgomery, Athens, March 12, 1946, aged 67.  
 Gostin, Bernard Singleton, Macon, August 28, 1945, aged 65.  
 Guffin, Thomas Frederick, East Point, November 22, 1944, aged 69.  
 Hanie, Arthur Paton, Hartwell, March 17, 1946, aged 77.  
 Harbin, Foster Pierce, Lumber City, June 15, 1944, aged 56.  
 Harrell, Sandy Byars, Macon, August 23, 1945, aged 77.  
 Hembree, James I., Atlanta, July 5, 1944, aged 54.  
 Hesse, Herman William, Savannah, November 24, 1944, aged 68.  
 Hilsman, Agnew Hodge, Albany, August 23, 1945, aged 69.  
 Hinton, John Willis, Atlanta, April 10, 1944, aged 74.  
 Hinton, William T., Dacula, May 17, 1945, aged 76.  
 Hoke, Michael, Atlanta, September 23, 1944, aged 70.  
 Holden, Alexander Stephens, Ellijay, April 16, 1944, aged 78.  
 Holliday, James Carlton, Athens, March 11, 1946, aged 60.  
 Hooten, John M., Woodbury, September 12, 1944, aged 83.  
 Hubert, Terrell Eugene, Milledgeville, September 21, 1945, aged 78.  
 Huey, Horace Gordon, Homerville, August 25, 1945, aged 54.  
 Humber, Jesse Weathers, Lumpkin, January 15, 1946, aged 56.  
 Johnson, Cleon Denton, Columbus, October 3, 1944, aged 50.  
 Johnson, Daniel Noble, Decatur, October 18, 1944, aged 93.  
 Johnson, Melville T., Atlanta, February 15, 1946, aged 78.  
 Johnston, J. J., LaFayette, December 17, 1945, aged 79.  
 Kelley, Charlie A., Lilburn, March 18, 1944, aged 72.  
 Kennedy, John Payson, Atlanta, September 17, 1944, aged 80.  
 Kennedy, Wallace D., Metter, December 28, 1945, aged 73.  
 Kesner, George T., Atlanta, April 16, 1946, aged 83.  
 King, George Wiley, Atlanta, January 12, 1946, aged 74.  
 Kinney, James R., Fort Valley, May 9, 1945, aged 82.  
 Liggin, Samuel B., Montezuma, October 2, 1944, aged 68.  
 Loveless, Jackson Cleveland, Grayson, August 4, 1945, aged 55.  
 Malone, Will Hale, Atlanta, July 10, 1944, aged 54.  
 Maloy, James Williamson, Rhine, September 1, 1945, aged 60.  
 Mashburn, Charles Marcellus, Atlanta, August 14, 1945, aged 55.  
 Mathews, James Hortmon, Rebecca, March 27, 1945, aged 59.  
 Mathews, William Lester, Winder, May 4, 1945, aged 58.  
 McAliley, Robert George, Atlanta, September 15, 1945, aged 66.  
 McCarthy, Daniel Joseph, Savannah, February 22, 1945, aged 37.  
 McCurdy, William Tarlton, Stone Mountain, February 13, 1946, aged 70.  
 McKenzie, Robert Douglas, Albany, October 27, 1944, aged 34.  
 Meeks, William Thomas, Blairsville, July 10, 1944, aged 70.  
 Middleton, Charles Seaborn, Blakely, February 13, 1946, aged 74.



Mitchell, Julius Shuford, Rome, December 2, 1945, aged 72.  
 Mulherin, William Anthony, Augusta, April 19, 1945, aged 72.  
 Nall, James Daniel, Atlanta, January 24, 1946, aged 64.  
 Noble, George Henry, Atlanta, February 12, 1946, aged 56.  
 O'Neal, Rance, West Point, September 11, 1944, aged 70.  
 Osborne, Lyman Sanderson, Fitzgerald, August 6, 1945, aged 90.  
 Palmer, Joseph Barnes, Thomasville, November 3, 1944, aged 67.  
 Payne, James W., Monticello, October 30, 1945, aged 56.  
 Petway, Thomas Franklin, Atlanta, May 22, 1944, aged 66.  
 Pirkle, John Arnold, Monroe, March 22, 1946, aged 66.  
 Pirkle, William Homer, Cochran, July 25, 1944, aged 66.  
 Power, Iron Clifton, Hiram, November 15, 1945, aged 69.  
 Reid, Charles Washington, Pelham, January 1, 1946, aged 78.  
 Revell, Samuel T. R., Louisville, January 13, 1945, aged 65.  
 Rhyne, William H. F., LaFayette, December 1, 1944, aged 81.  
 Robinson, Walter C., Atlanta, June 17, 1944, aged 88.  
 Rose, John Rudolph, Sale City, aged 88.  
 Sanford, Eugene Farmer, Buchanan, August 2, 1945, aged 55.  
 Savage, James Henry, Atlanta, February 8, 1945, aged 62.  
 Schwalb, Otto W., Savannah, April 17, 1945, aged 43.  
 Scruggs, Samuel Andrew, Americus, February 26, 1944, aged 54.  
 Sears, William D., Ellaville, March 14, 1945, aged 68.  
 Sessions, Walter Wesley, Sumner, May 21, 1945, aged 70.  
 Shallenberger, William Farquhar, Atlanta, December 16, 1944, aged 63.  
 Shellhorse, Evan Otis, Dalton, November 19, 1945, aged 67.  
 Short, Bland P., Newton, February 29, 1944, aged 77.  
 Smith, Benjamin L., Forsyth, July 7, 1945, aged 63.  
 Smith, Charles Sherman, Clarkesville, February 11, 1946, aged 82.  
 Smith, Marvin R., Cordele, July 12, 1943, aged 66.  
 Smith, William Thomas, Tifton, December 8, 1945, aged 69.  
 Spearman, Walter Dudley, Social Circle, April 30, 1945, aged 69.  
 Stephens, Charles Manfred, Waycross, February 26, 1946, aged 63.  
 Stephens, Lee D., Sycamore, February 12, 1945, aged 63.  
 Stewart, Thomas Hill, Jr., Eastman, January 6, 1944, aged 51.  
 Swain, William H., Martin, May 20, 1945, aged 76.  
 Swanson, Benjamin C., Jr., Atlanta, March 17, 1945, aged 62.  
 Swint, Roger C., Atlanta, August 8, 1945, aged 70.  
 Thomason, John Washington, East Point, December 19, 1945, aged 65.  
 Timmerman, John Patterson, Hephzibah, February 25, 1944, aged 69.  
 Tipton, Walter Charles, Sylvester, December 12, 1944, aged 62.  
 Tolhurst, George Monroe, Atlanta, June 27, 1944, aged 69.  
 Turk, John Pierce, Nelson, October 26, 1944, aged 65.  
 Walker, Robert Carroll, Waycross, January 9, 1943, aged 54.  
 Walkonig, Christian, Atlanta, April 13, 1945, aged 67.  
 Ware, Robert Mayhue, Fitzgerald, October 23, 1945, aged 62.  
 Wells, James R., Stone Mountain, January 1, 1945, aged 72.  
 Whiteley, Seals Leftwich, Cedartown, March 29, 1946, aged 66.  
 Wiggins, Lee Wilbert, Atlanta, July 20, 1944, aged 68.  
 Williamson, Johnathan Wooden, Atlanta, April 27, 1943, aged 29.

Willbanks, George P., Rossville, April 2, 1946, aged 88.  
 Woods, James Edgar, Atlanta, February 3, 1945, aged 77.  
 Young, William Walter, Atlanta, September 7, 1945, aged 55.

In analyzing the years attained by these 140 doctors, the record shows that 50 lived to be 70 and over, and at that advanced age, when the years required greatly lessened activities, so many of them came forth heroically and rendered professional services to meet the overwhelming need when the cream and flower of our medical men were in foreign lands and on the seven seas rendering their services that our country might survive and help to lead the world back to sanity and the finer things of life; that 73 died between the ages of 50 and 69; 10 died from 40 to 50; and the remaining number did not reach the age of 40. In the years from 1941 to 1945 when the very foundation for an orderly world was shaken by enemy forces, Georgia doctors were spared from a high mortality. Six hundred of them answered their country's call and of that number, Dr. R. D. McKenzie, of Albany, made the supreme sacrifice during naval action in the Pacific. Dr. George F. Eubanks, of Atlanta, died of coronary thrombosis while on duty with the Army in England. Dr. D. J. McCarthy, of Savannah, lost his life on Iwo Jima. The sounding waves and the winds of foreign lands sing for them an everlasting requiem.

It is unfortunate that the terminal disease has not been given in the mortality reports. A comparison of such can be gathered from the mortuary column as given in *The Journal of the American Medical Association*. On such basis it can be estimated that 30 to 35 per cent were due to that nemesis of doctors, coronary disease, or cardiovascular-renal disease and other terminal disease depending thereon. Why this is the case there is no answer; but one wonders if carrying in his heart the mental worries and burdens of his fellowman, secrets that the

world cannot know, might be one answer. Biographies are milestones that mark the imprint of the individual in his life work, his community and the influence for the future welfare of society and the field where he labored.

As sorrowing friends and patients assembled to pay the last tribute of love and respect, heartfelt encomiums were spoken by men of God and his friends. In all of their lives of service they had witnessed the two mysteries—life and death. On so many occasions they had ushered into this world the tiny flickering spark of life in birth. On so many occasions they had stood in the presence of the other mystery—death. They had caught the significance of its meaning—the beginning and the end of existence.

Almitra said to Almustaafa, the Prophet, We would ask now of Death.

And he said:

You would know the secret of death.

But how shall you find it unless you seek it in the heart of life?

If you would indeed behold the spirit of death, open your heart wide unto the body of life.

For life and death are one, even as the river and the sea are one.

Your fear of death is but the trembling of the shepherd when he stands before the king whose hand is to be laid upon him in honour.

For what is it to die but to stand naked in the wind and to melt into the sun?

And what is it to cease breathing, but to free the breath from its restless tides, that it may rise and expand and seek God unencumbered?

The Apostle Paul would also speak of death:

Behold, I show you a mystery; We shall not all sleep, but we shall be changed,

In a moment, in the twinkling of an eye, at the last trump: for the trumpet shall sound, and the dead shall be raised incorruptible, and we shall be changed.

For this corruptible must put on incorruption, and this mortal must put on immortality.

So when this corruptible shall have put on incorruption, and this mortal shall have put on immortality, then shall be brought to pass the saying that is written, Death is swallowed up in victory.

O death, where is thy sting? O grave, where is thy victory?

#### OUTLOOK FOR CHILDREN WITH DIABETES

"What chance has a seven year old child of recovering from diabetes?" a reader asks in the current issue of *Hygeia*, health magazine of the American Medical Association.

"Complete cure of diabetes (that is, elimination of this condition) is not possible," states *Hygeia*. "However, as a result of medical advances it is possible to assure the average diabetic child of practically as long a life as any other person. In fact, at least one insurance company is now accepting policy applications from diabetics. It must be realized though that rather strict supervision is necessary in all patients with diabetes and frequent medical consultation is advisable."

## UNDULANT FEVER, AN INCREASING MENACE TO HEALTH IN GEORGIA

CHAS. E. ZIMMERMAN, M.D.

*Tifton*

This is not intended to be a complete treatise on undulant fever, but is a short paper for the purpose of reminding us that undulant fever is definitely on the increase.

Undulant fever is an acute and chronic disease with protean manifestations, characterized by fever, weakness, sweating and various aches and pains. It is caused by general infection with a member of the abortus group of organisms. Of this organism there are three groups: the brucella carpinus, or goat type; the brucella porcine or hog type; and the brucella bovinus or cattle type. In this country we are chiefly interested in the hog and cattle types. It is particularly interesting that the hog type frequently infects cattle and that perhaps a greater percentage of cases in this country are of the porcine variety.

The disease is chiefly contracted by drinking infected, nonpasteurized milk but the handling of infected material, such as hides or meat, may be its means of spread. It is definitely on the increase in Georgia. In 1944 the number of cases reported to the Georgia Public Health Department tripled that of 1935. There are undoubtedly many more cases that have gone unrecognized, due to the difficulty in diagnosis and the differences in manifestations.

The mortality rate is as a rule very low, averaging about one to three per cent. Most cases run a fairly long and drawn out course; in rare instances it is very malignant.

The very fact that undulant fever manifests itself so differently in separate cases prevents its being classified into definite



types, but for purposes of discussion we shall attempt to take up cases showing various clinical pictures.

# REPORTS OF CASES

*Case 1.* A white housewife aged 29 gave a history of having had three attacks of fever within four months. In each attack there had been a fairly mild onset, with headache, general malaise, severe aching of her back and legs and marked anorexia. The fever was said to have gone as high as 104 F., and the attacks had lasted from two to three weeks with intervals of one to two weeks between exacerbations. Upon first seeing her she was in the declining stage of one of these attacks. Physical examination showed a pale, thin, anemic white female; T. 99.2 F., B.P. 96/60, pulse rate 92. All other physical findings were normal. The Hb. was 60 per cent, W.B.C. 10,200; agglutination for undulant fever 4 plus positive. Blood culture, which was reported later, was positive.

She was given sulfathiazole sodium tablets two four times each day for 6 days, a good general tonic, and undulant fever vaccine was begun. Within six days she was feeling much better and having no fever. Within 21 days she had gained considerable weight and was beginning to feel well again. The vaccine was continued until three 5 c.c. vials had been given. Blood culture was then negative even though, as would be expected, the agglutination reaction was yet positive.

Here we have a case of typical, undulating fever with mild onset and rapidly increasing severity followed by a gradual decline of symptoms.

*Case 2.* An elderly white male aged 78 presented himself with a history of fever every day for two and one-half months, ranging from 99.5 to 101 F. With this he had experienced very little discomfort. During the hours he had fever he suffered general malaise with slight to moderate aching of his joints and limbs. The fever usually came on in the afternoon and lasted from six to ten hours. During the rest of the day he was fever free. During his illness he had taken 75 tablets of atabrine with no results. Physical examination showed only anemia, temperature 100 F., and evidence of weight loss, with discoloration of the skin from the atabrine. During this time he had lost about 25 pounds. Blood agglutinations for typhoid, typhus, tularemia, undulant and smears for malaria all were negative. Blood culture was negative. Skin test for undulant fever was positive. Chest x-ray study was normal. Tuberculin skin test was negative.

He was started on undulant fever vaccine, and antipyretics were discontinued. Within a few days he was feeling much better, and after three vials of vaccine remained fever free and felt quite well. This case I am reporting to illustrate the fact that many people never show a positive blood test. This is an example of the ambulant type of undulant, with low grade fever and mild symptoms. Only the skin test offered a diagnosis.

*Case 3.* A white male farmer, aged 24, came in with a history of having had a positive blood test for undulant fever for 31 days, during which time he had had only symptomatic treatment. He had been continuously bedridden since the onset of his illness. His outstanding symptoms were fever, which was highest in mid-afternoon; severe headaches; profuse sweating; abdominal pain, most marked in the left upper quadrant; anorexia, constipation, weakness and weight loss. Physical examination showed: T. 100.8 F., eye, ear, nose and throat negative, chest and heart negative; B. P. 100/70, pulse rate 120, the spleen enlarged one finger-breadth below the lower costal margin and very tender. The urine was normal; Hb. 70; blood culture and agglutinations for undulant fever were positive.

He was given vaccine therapy, sulfathiazole sodium for one week, and lubricating and bulk-increasing laxative.

After four days he remained fever free and was definitely on the upgrade. The vaccine was continued for four weeks from the beginning. Blood culture taken at this time was negative.

Here we have a case presenting splenomegaly, which is not a frequent finding in early cases. Too, he had a continuous fever rather than the exacerbations expected with a typical undulant.

The diagnosis of undulant fever may be quite easy or very difficult. In typical cases it is easily recognized from clinical symptoms, but in the atypical cases it may be extremely evasive. Blood culture may be positive but frequently there is an intermittent bacteremia, so that unless repeated cultures are taken it can be missed entirely. The State Laboratory will furnish these culture outfits upon request. After the first week agglutinins may or may not be present, but often they are not found at all or not until late in convalescence. If agglutinins are not demonstrable in suspected cases a skin test with 0.05 c.c. of 1:500 or 0.1 c.c. of 1:1000 solution of brucellin should be made. This test material can easily be prepared by taking 0.1 c.c. of the treatment vaccine and diluting with 0.9 c.c. of normal saline. One tenth cubic centimeter of this dilution is injected intradermally and the test read after 48 hours. A positive test consists of a red area at the site of the injection, with an indurated nodule beneath. Unless this palpable nodule is present the test is probably negative even though some redness exists. A positive skin test means that there is present or past infection, therefore it must be correlated with the clinical picture.

The treatment of undulant fever includes all those measures applicable to acute infections; that is, symptomatic relief and bed rest. Specific treatment is not on a firm basis but I think the most effective method is as follows:

Sulfathiazole sodium tablets, 2 every four to six hours for six days or until the fever is gone. At the same time undulant fever vaccine is begun subcutaneously.

There should be at three-day intervals two injections of 0.25 c.c., two of 0.5 c.c., then two of 0.75 c.c. After this 1 c.c. is given twice a week until from two to three 5 c.c. vials have been used, or until the blood culture is negative. What streptomycin will offer is yet to be seen. Various dyes have been advocated for intravenous use but reports on these are, as a whole, not gratifying.

In conclusion, I may say:

1. Undulant fever is definitely an increasing menace to health in our State, and unless proper preventative measures are taken it will become progressively worse.

2. It is frequently an evasive disease, requiring time and persistence in our efforts to diagnose it.

3. Blood culture and agglutination tests may be negative, and many cases can be diagnosed by skin test only.

4. We must become more mindful of its existence and give it proper consideration in any unexplained fever or chronic illness.

5. While most cases can be cured, recurrences after long periods of time are not so infrequent that we can afford to forget them.

6. The combination of sulfathiazole sodium and vaccine has relieved all patients that I have treated.

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#### MENTAL HYGIENE CLINIC

Opening of a mental hygiene clinic in Atlanta for the treatment of veterans with service-connected nervous or mental disorders, was announced recently by the Veterans Administration.

The clinic is operated in conjunction with the VA Regional Office at 105 Pryor Street, Atlanta, and is open from 8 a. m. until noon, Monday through Friday.

Dr. J. A. McAllister, chief medical officer in the regional office, said until additional space and personnel are made available, the personnel on duty will be confined to a psychiatrist, a psychologist and a psychiatric social worker. The present staff will be able to assist each week on an average of 30 veterans who have adjustment problems and personality difficulties.

The clinic is the first to be established by the VA in Georgia. Under present plans, similar clinics have been proposed for Savannah, Macon and Valdosta, where sub-regional offices are maintained by the VA.

Robert M. Hughes, chief psychologist and director of the separation counseling program at the former Army Lawson General Hospital, heads the Atlanta clinic.

## STAPHYLOCOCCUS HEMOLYTICUS BACTEREMIA

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### *Report of Case With Recovery*

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I. B. CANTOR, M.D.

*Atlanta*

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In spite of the fact that the literature contains cases of recoveries from staphylococcus bacteremia, the numerous fatalities that still occur call attention to the seriousness of this illness. Fortunately, with the advent of present-day chemotherapy, we have additional medical armamentarium to combat this dreaded condition.

Anderson and Keefer reported in the September 1944 issue of *Medical Clinics of North America* that penicillin has lowered the mortality rate of staphylococcic bacteremia from 85 to 20 per cent, and that in serious staphylococcus infections without bacteremia the recovery rate is even higher than 80 per cent. It was also clearly shown by these writers that when an infection becomes localized in a serous space, such as a pleura, it is necessary to inject the drug directly into the infected cavity. The mode of action of penicillin is that it prevents the growth and multiplication of the infecting organism and the actual killing of the bacteria is done by the phagocytic cells of the host. Thus, in order to adequately treat a resistant infection, such as that caused by the staphylococcus, it is necessary to keep up prolonged and intensive therapy. These authors reported a case of a 2-year-old girl with staphylococcus pneumonia with bacteremia who made an uneventful recovery with sulfadiazine and penicillin therapy.

As for the value of sulfadiazine in staphylococcus bacteremia, Norman reported in February 1944 a case with complete recovery. This patient had a right basal pneumonitis; a positive blood culture for staphylococcus aureus; an ulcer on the right



cornea; multiple skin nodules; and an abscess on the right thigh. He received 60 Gm. of sulfathiazole and 100 Gm. of sulfadiazine, as well as blood transfusions, general supportive therapy and drainage of abscess in thigh. This patient made an uneventful recovery after an illness which lasted about two and one-half months.

Similar dramatic results have been reported by Herrel and Nichols of the Mayo Clinic, Champ Lyons of the U. S. Army, and a host of other writers.

The patient's history which I am now going to present is an example of what can sometimes be accomplished with a moribund patient by means of chemotherapy and generalized supportive therapy.

This patient was a 25-year-old, unwed, white female, and in good health until Sept. 8, 1945, at which time she was awakened in the middle of the night with a severe pain in the anterior lower left chest, which was aching in character and aggravated by respiration. The next day the pain in the chest continued and she was aware of soreness behind her left ear. On the third day she complained of headache, fever, vomiting, pain in her left chest, and pain behind her left ear which made her consult a physician. An ointment was prescribed for the eruption behind her left ear and left side of her neck. In addition, she was instructed to take 2 sulfadiazine tablets three times daily. The sulfadiazine apparently caused great mental symptoms of confusion and the patient discontinued her medication after having taken only 7 tablets. The fourth day of her illness vesicles appeared on the skin behind her left ear and the pain became more pronounced on the left side of her neck. The pain in the chest persisted and she felt shortness of breath when lying on her back and preferred to lie on her right side. The fever persisted and became elevated, although there were no chills. She seemed to make no improvement and was becoming more toxic, so her physician sent her to Grady Hospital with a diagnosis of erysipelas.

Her past history was essentially negative except that she had scarlet fever at 6, and a laparotomy at 21. She had never had edema of the extremities or attacks of arthritis. However, for the past 5 to 6 years she has had dyspnea on climbing stairs and frequent attacks of palpitation without any unusual emotional or physical exertion. At the time of the laparotomy, in 1941, she was told that she had a heart murmur.

On admission to Grady Hospital her temperature was 103.2 F., pulse rate 130-140, respirations 26, and B. P. 110/60. The patient appeared acutely ill and was lying on her right side. On the lobe of the left ear and the post-auricular region of neck was an area of erythema with numerous small vesicles and pustules. Although there was tenderness over the area of erythema and the left side of the neck, there was no significant lymphadenopathy. The pupils were normal and the conjunctivae and fundi revealed no petechiae. The nose and throat were normal. The lungs were apparently clear to auscultation and percussion on admission. The heart was not enlarged but had a rapid rate and suggestion of a gallop rhythm. There was tenderness in the left upper quadrant of the abdomen and some voluntary

spasm; no organs or masses were palpable. The cervix was slightly enlarged and revealed some bluish discoloration, but no tenderness was present. Rectal examination was negative. On the medial aspect of the left upper arm were two small erythematous indurated areas about 3 cm. in diameter. The neck was not stiff and the neurologic examination was negative.

The laboratory data revealed a negative Kahn; 2 plus albumin in urine; 13.2 Gm. Hb.; Sed. rate 45; W.B.C. 7,850; 6 juveniles; 30 stabs; and 60 segs. The agglutination series was not remarkable. X-ray examination of the chest showed some increase in the lung markings throughout both lower lung fields, especially on the right side.

Her temperature remained elevated and the day following admission to the hospital there were seen scattered over the body, back, upper legs, and upper arms, about 30 indurated erythematous lesions which blanched on pressure. On September 14 rales were heard in the right lower chest. Auscultation of the heart also revealed a faint presystolic murmur at the apex. However, because of the rapid heart rate, it was difficult to definitely determine the presence of the murmur. Three blood cultures taken on admission were positive for hemolytic staphylococcus aureus, and the patient was given 12,500 units of penicillin every three hours. Subsequently the dosage was increased to 25,000 units every two hours. In addition, she was given sulfadiazine, grains 4 every four hours. Her temperature was still 102 degrees F. at the fourth day of medication, and her W.B.C. had risen to 16,900 with essentially the same differential picture. On September 16 she was placed under my care, and was transferred to another hospital.

Upon admission to Jesse Parker Williams Hospital I ordered for her 15 grains of sulfadiazine every four hours; penicillin, intramuscularly, 25,000 units every three hours; and general supportive treatment with becllysyl intravenously. Her urinalysis the next day revealed a faint trace of albumin; 4 plus bacteria; 2-4 R. B. C.; 0-2 pus cells. Her R. B. C. was 3,700,000; W. B. C. 33,600; Hb. 73.4 per cent (11.3 Gm.); bands 25; Seg. 62; total polys 87; total lymphs 13. Her temperature at this time was ranging from 101.2 to 102.8 and her pulse rate, which was irregular, was 118 to 120. Her respirations, which were rather labored, ranged from 28 to 24. In view of her blood count and her toxic condition it was decided to give her a blood transfusion. Consequently, after determination of her blood type and Rh factor, she was transfused with 500 c.c. of whole blood. The patient seemed to gain strength following the transfusion and appeared to be brighter on the next day. The lesions on the back of the ear and scalp were still draining a serosanguinous exudate and hot wet packs to this region were ordered every three hours. On September 18 5 Gm. of sulfadiazine in 200 c.c. of triple distilled water were given intravenously at the rate of 40 drops a minute. Her penicillin was increased at this time to 50,000 units every three hours. A portable x-ray study of the chest on September 19 revealed a suggestive opacity over the base of the right lung field extending upward along the periphery to the apex. The left lung revealed a marked infiltration suggestive of a bronchial pneumonia. Since her blood sulfadiazine was 7.4 mg. per cent September 18, 5 Gm. of sulfadiazine were given intravenously. Blood culture obtained at this date was found to be negative five days later. Her fluid intake at this time ranged from 1800 to 2400 c.c. every 24 hours with an output of 900 to 1200 c.c. Because of nausea the sulfadiazine was reduced to 15 grains every eight hours.

On the afternoon of September 19 her respirations were quite labored and had risen to 38 a minute; her pulse rate ranged from 120 to 130. She was placed under an oxygen tent and coramine was ordered as needed. The next day 500 c.c. of whole blood were administered. Examination of her chest revealed numerous rales in the left lung and dullness on percussion, with a suggestive shifting fluid level on the right chest. The sedimentation

rate September 21 was 56 mm. per hour and the W.B.C. at this time dropped to 6,650 with 71 per cent polys and 3 bands. Next day, a thoracentesis was performed in the right post-axillary line at the 9th interspace and 650 c.c. of serous fluid were aspirated. Culture of this specimen was negative. At the time of the aspiration of the pleural exudate, 50,000 units of penicillin in 100 c.c. of normal saline were injected into the pleural cavity. After this her respirations became more regular and the oxygen was discontinued. However, her pulse continued to be quite fast and irregular.

Her condition continued to remain very serious and her temperature ranged from 98.6 to 102 with a pulse jumping from 94 to 130. On September 24 her R. B. C. was 3,900,000; W. B. C. 22,020; Hb. 77.3 per cent (11.9 Gm.); polys 84; Seg. 69; bands 14; Lymph 10; and 6 monocytes. She was given another transfusion of 500 c.c. of whole blood, which seemed to give her added strength and improved her condition in general.

On September 26, upon thoracentesis of the right pleural cavity, 250 c.c. of serous fluid were aspirated and once more 50,000 units of penicillin in 100 c.c. of normal saline were injected into the pleural cavity. Laboratory cultures of this specimen were also negative.

There was no great change in her condition for the following week except that the indurated lesions on her body, back, legs and arms disappeared; the skin lesions in her scalp and post-auricular region were drying up; and her temperature peak was 101, with a pulse rate of 116 to 120. Her sedimentation rate on October 1 was 57 mm. and five days later it increased to 75 mm. an hour. X-ray examination of the chest October 2 revealed a small amount of fluid in the right base, with a fluid level at the 8th rib. The right lung continued to show considerable infiltration in the lower lobe. At this time her penicillin was increased to 100,000 units every three hours. Since it was felt that she was well saturated with sulfonamides and was beginning to become extremely nauseated, the sulfadiazine was discontinued on October 5. Another blood culture October 5, as well as agglutination tests, were all reported negative by the laboratory. X-ray examination of the skull was negative for osteomyelitis, and a urinalysis also was essentially negative. A complete physical examination was done October 7 and the only findings were rales throughout the left lung and the right base; a rapid irregular pulse; presystolic apical murmur; a liver which was enlarged to three finger-breadths below the right costal arch; and some scaly lesions on the right post-auricular region and the scalp. The vaginal and rectal examinations were negative.

In spite of this protracted illness her general condition remained good, which I attributed to frequent small blood transfusions of 250 c.c. of whole blood; the administration of 300 mg. of vitamin C a day; and one unicap daily, as well as general supportive therapy with adequate fluid intake and output.

However, since there was no great change in her temperature, her pulse rate, and sedimentation rate, the possibility of a subphrenic abscess was investigated. X-ray examination of the lumbar region revealed a partial obliteration of the left psoas muscle. Upon urologic consultation and intravenous pyelograms, it was decided that there was no disease in the left kidney or in the left perinephritic area.

On October 10 the penicillin was reduced to 40,000 units every three hours, but a sedimentation rate two days later showed a reading of 84 mm. in one hour. This was the highest figure that her sedimentation rate reached throughout her whole illness. On October 14 a thoracentesis was performed once more into the right pleural cavity but no fluid could be aspirated. However, 100 c.c. of 50,000 units of penicillin were injected once more into the right pleural cavity.

On October 21 the penicillin was reduced to 25,000 units every four hours and on October 27 it was discontinued. This was the forty-first day under my care and her temperature peaks throughout the previous week

ranged from 99.4 to 99.8 with a pulse ranging from 80 to 100. Her sedimentation rate had been ranging from 27 to 47 during the previous fortnight and finally on October 29 it was 7 mm. in an hour.

The patient, now on a general diet, continued to show improvement and her temperature became normal and remained so. Her respirations were 20 to 28, regular; and the rales in both lung areas disappeared. The pulse rate still was irregular and ranged from 70 to 80 during the last week of her hospitalization. The liver margin was only one finger-breadth below the right costal margin and examination two weeks later, at the office, revealed that it had receded under the costal margin. The heart did not seem to be enlarged to percussion but it was still irregular and a distinct presystolic non-radiating, apical murmur could be heard. Finally, she was allowed to sit up out of bed, and on November 2 she walked out of the hospital.

An electrocardiogram by Dr. Harry Parks, before she left the hospital, revealed sinus tachycardia, auricular extrasystoles and P waves peaked in leads 1 and 2. The QRS complexes were normal in all leads except low in CF-5. The T waves were upright in leads 1 and 2 and flat in lead 3. The T waves were low but upright in the chest leads. This picture is suggestive of old myocardial damage.

This patient received 105 Gm. sulfadiazine by mouth and 10 Gm. intravenously; 18,620,000 units of penicillin intramuscularly and 150,000 units intrapleurally. She was febrile for 49 days and was hospitalized for 56 days. About six weeks after her discharge from the hospital she returned to her duties as a secretary.

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#### DOCTORS NEEDED FOR OVERSEAS MISSION HOSPITALS

The worldwide medical enterprise of the Protestant Church is in urgent need of surgeons and physicians for general hospitals, and also specialists in various branches for teaching centers. There are appeals for personnel from every quarter of the globe. These include special calls recently from Liberia, Alaska, devastated areas of China, the Congo and the Cameroons, for general surgeons and physicians, as well as specialists—otolaryngologist, thoracic and orthopedic surgeons, clinical pathologist, anesthesiologist, neuropsychiatrist and internist—for service on the staffs of Christian medical colleges in India and China.

Applicants should be members of one of the regular Protestant denominational churches and imbued with a spirit of Christian service. The average pay is approximately \$80 a month for a single person, double for married couples; which, together with certain allowances (children's, etc.) and the provision of living quarters, permit of a fairly high level of living in the country to which the missionary is appointed.



Those interested are asked to communicate with the Secretary, Christian Medical Council for Overseas Work, 156 Fifth Ave., New York 10, N. Y.

### EXPERIENCE WITH DEMEROL IN EUROPE

*To the Editor:*—The following observations may be of interest to you with regard to the controversy between Dr. C. K. Himmelsbach, Chicago, Mr. H. J. Anslinger, Washington, D. C., and Paul de Kruif, Ph.D., Holland, Mich. (*THE JOURNAL*, September 7).

In the spring of 1945 I acted as liaison officer between First Army Headquarters and a central "German Sanitary Staff" established temporarily to maintain the function of the large number of captured German medical installations. Repeated inspections of hospitals and numerous trips throughout the occupied area gave me an opportunity to become familiar with administrative and technical experiences and difficulties encountered by the German army.

A tragic accident led me to investigate the use of Demerol by the medical department of the German units then under our control. Allied troops which had opened a medical depot found a large stock of an alcoholic preparation of Dolantin (the German trade name for Demerol), mistook it for a beverage and drank numerous bottles; a large number of casualties resulted.

Consultation with German medical officers and pharmacists revealed that the staff had at this time 40 cases of known Demerol addiction in its files; that, furthermore, a large number of hospitals had abandoned its use for this reason. It is interesting to note that in Germany too it had been assumed for some time that Demerol was less addicting than morphine, a theory which had been revised by the spring of 1945.

Subsequently I was called repeatedly by military government officials to examine cases of Demerol addiction in civilians. I remember one instance which illustrates convincingly the danger of the drug. A physician addicted to morphine submitted twice to treatment. After the second treatment he was advised to try Demerol and developed within three months an addiction to the substitute. During this period he performed an abortion and was committed to a sanatorium for clinical study. After several weeks an attempt to withdraw the drug was made; he developed no symptoms of withdrawal. It was suspected, therefore, that he had managed to obtain considerable quantities of the drug. Careful isolation revealed not only that his wife in weekly visits had issued Demerol to him but that she herself—after having taken the drug once or twice as a sedative, following her husband's confinement—had become a Demerol addict.

Although the case histories on pages 43 and 44 of the September 7 issue of *THE JOURNAL* contain convincing evidence against Paul de Kruif's statement, it might be helpful to add these experiences to the warning.

MAX SAMTER, M.D., Chicago.

J. A. M. A.  
Sept. 28, 1946

### THE DOCTORS IN NORMANDY

For the past ten months I have been interested in the doctors in Normandy, and especially those in Caen, which is only twelve miles back from the coast where the allies landed on June 6, 1944. I have been in communication with a number of these doctors, and I have found out that, although they insist that they "are not in the most unfortunate group," as a matter of fact, many of them have suffered terribly. One doctor lost his mother and a three year old child on June 7, 1944, when a bomb from one of our own planes dropped on them. His only son had both eyes torn out and a six year old daughter was blinded in one eye and only has 1/20 vision in the other. I know another doctor who was horribly wounded and two others were killed in the operating room by the same bomb. Our confreres write me that they have no luxuries, and that life is utterly

drab. The wives and mothers of the doctors in Caen are having to wear wooden shoes and food is limited and poor.

I am afraid that many of us doctors in Georgia are not entirely familiar with the situation of Caen with reference to our invasion of Normandy. The troops landed only twelve miles away and I have a most graphic description of this landing in a letter from Madame Le Mercier, who is the mother of a young doctor in Caen. The villages on the beach were taken in a few hours but the Germans had to defend Caen most stubbornly since a number of highways crossed there, and the Germans hoped to use Caen as a base and push us back into the sea. The American bombers had to destroy this French city since it housed many Germans and the highways passed through it. The civilians were given no notice and the bombing started on the morning of June 6 continuing until July 10, when the Germans were driven out and then they in turn began to shell the city as the English and Canadians came in. The first estimate which I received was that 15,000 civilians were killed out of a population of 60,000. This was wrong, only 5,000 were killed, but this was one in twelve, and beside this there were many wounded. There were forty civilian doctors in the city and college.

I am quite sure that we doctors can secure good clothing which has been used but which still has much wear left in it if we try to do so. In July a dear friend of mine died who had been on a bank board with me. His widow knew of my interest in the people in Caen and she sent me every stitch of his clothing from shoes to hats. All of these went forward to the doctors in Caen and the suits and underclothing and shirts have been Godsend to them. This man had many socks, and the doctors in Caen have written that they are the first decent socks they have had in several years. I am quite sure that we doctors ourselves can send some clothing, and I am equally sure that our patients can send more if we ask them.

A number of us here in Macon have been sending food and clothing to Caen for many months. The school children have contributed sugar and it has been collected and packed by the Boy Scouts and Girl Scouts. This is going forward daily by mail; 2,501 pounds of sugar have been contributed and it is going forward rapidly. A number of us have sent personal packages of clothing and shoes to the doctors in Caen, and these are most gratefully received. They are being sent to Madame S. Lebailly, who is the widow of the dean of the medical college and the mother-in-law of another doctor who lives with her. As we send these packages of clothing we instruct this lady, who is a real lady, that she may keep out whatever she desires for her own family and then pass it along to the other doctors and the poor in her community. They literally need everything from socks to coats. Packages must *not* weigh over eleven pounds and the postage is fourteen cents per pound.

I would like to suggest that individual doctors and their wives send such packages, but if you prefer good clothing, meaning used clothing which still has wear left in it, may be sent to me and we will mail it to Caen. It is necessary to use two names, and we use as an alternate, the name of Dr. Frank Duncombe, Regional Boy Scout and Girl Scout Director, 98 Boulevard Des Allies, Caen, Calvados, France. Madame S. Lebailly's address is 68 Rue St. Martin, Caen, Calvados, France.

One of the most acceptable presents has been cotton flannel which costs only twenty cents a yard wholesale. This is accepted as if it might be silk or brocade. I have never seen such gratitude as is expressed by these doctors and their families and I sincerely hope that the doctors in Georgia and their wives will send packages including toys for the little children before Christmas. We should not send any toys which remind the children of war, no toy pistols nor guns nor airplanes, although of course all children like toys which make noise.

CHARLES C. HARROLD, M.D.  
Macon.

**THE JOURNAL**

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

NOVEMBER, 1946

ANNUAL SESSION OF THE  
ASSOCIATION

The 1947 annual session of the Association will be held at the Bon Air Hotel, Augusta, April 22-25.

This should be a normal session in every respect. In other words, there should be available an ample supply of scientific papers, and numerous scientific exhibits. But it should be remembered that both time and effort are required to prepare a good paper and good illustrations and then shape each of them to fit the time allotted for their presentation. With this in mind those members who actually participate in our annual session could, if they would, do much to improve the standing of medicine so far as our State is concerned; and this Journal would reflect a better medical picture for all concerned, particularly for many people who live in foreign lands, to whom it is sent regularly.

Some of the common errors in writing medical papers are: "I then put him on 5 grains of aspirin every 4 hours." The question might be raised, Who among us could sit on, or be put on, five grains of aspirin? Or "The next morning he had no temperature." It would be better to say he had no fever. There are numerous other errors made in the writing of medical papers, and sometimes even the editor fails to correct many errors. For example, most of us, in our efforts to shroud the identity of a patient, will say: "I operated on a case of so-and-so and then so-and-so happened." It should be remembered that we physicians

deal with human beings and when we do an operation it is for a patient and not for a case. Of course, it is possible to operate on a case of oranges, or on a case of tomatoes or even on a case of liquor, but it would be most difficult for one to operate on a case of human beings. If not difficult, who among us is willing to make the effort?

So those of you who plan to read papers before the next annual session should begin now to get ready for that event. And those who, from year-to-year, procrastinate and fail to obtain hotel accommodations before the rush to the meeting, should by all means make ready for what will be a real rush April 22-25, 1947; namely, a rush to attend a fine session of the Medical Association of Georgia. Finally, those members who wish to display scientific exhibits at this session also should get ready so their exhibits may be placed before the meeting is under way.

## ABSORBABLE HEMOSTATIC GAUZE

From time immemorial surgeons have been plagued by hemorrhage which could not be controlled by the orthodox method of hemostat and ligature. We refer particularly to bleeding from the brain, liver, spleen, kidney and from large denuded areas. Many times hemorrhage of this kind has been controlled by pressure packing with gauze sponges and packs. This method, while often-times lifesaving, has the disadvantage that the gauze is nonabsorbable, somewhat irritating and must be removed ultimately. Its removal may tear away natural clots and result in secondary hemorrhage.

During the last war a number of hemostatic agents were developed in the various experimental laboratories. Among them was an absorbable, nonirritating hemostatic gauze. During the stress and strain of the war it was envisioned that there might be a gauze that a medical corpsman could re-



move from a sterile container and while in the field stanch the hemorrhage of a soldier where he had fallen, despite the fact that the hemorrhage might be from a gaping wound in the liver or kidney or some other source of usually fatal hemorrhage. Such a gauze has been developed and has begun to appear on the market. Its development came too late to be of great value in wartime medicine, but it now bids fair to fulfill one of the all time dreams of surgeons; that is, a gauze that may be packed into a wound to control hemorrhage, that will be non-irritating, and will be absorbed by the natural body fluids.

To Kenyon and his associates of the research laboratories of the Eastman Kodak Company go the credit for the original work. To Clark and Frantz of the College of Physicians and Surgeons of Columbia University go most of the credit for the research in the clinical application. Kenyon and his associates oxidized ordinary cellulose surgical gauze with nitrogen dioxide, converting it into cellulosic acid, and produced a substance which looks and feels very similar to ordinary gauze but which is quite different in its chemical composition and certain of its physical properties. It possesses a marked hemostatic quality, and is completely and rapidly absorbed from the various tissues of the body. There is little or no tissue reaction and it disappears from the site of implantation in a few days.

When the gauze comes into direct contact with the slightly alkaline blood and tissue fluids it is quickly transformed. The gauze seems to melt into an expanding gelatinous mass which fills all the crevices of the wound and immediately controls the hemorrhage. This gelatinous mass turns dark brown in color, probably due to affinity for or reaction with the hemoglobin of the blood. Thus we have bleeding controlled in

two ways—first, by a mechanical packing of the wound; and secondly, by a chemical reaction between the gauze and the blood. The rate of absorption depends upon the amount of gauze used and the amount of blood present. Paradoxically, the more the bleeding the quicker the hemostasis because more gauze is dissolved into the formation of the hemostatic gelatinous mass. The change in the gauze from its ordinary form to the gelatinous mass is dependent primarily upon a change in the hydrogen ion concentration. The gauze itself is slightly acid and is very quickly dissolved in a slightly alkaline medium with the pH approximately that of blood.

After a hemorrhage has been controlled with this gauze the bulk of the mass may be lifted away with safety because of a protective film between the undersurface of the mass and the raw tissue. This phenomena, it would seem, would make it safe to use to pack a clean closed wound or to pack an open infected wound without the danger of secondary hemorrhage.

Our knowledge of this gauze has been obtained from what we have read in the literature and our experience with the actual gauze in a small series of cases limited to the field of urology.

In removing renal calculi where it is necessary to make an incision in the cortex of the kidney and where profuse hemorrhage, often difficult to control, is expected, we have found it feasible to pack the incision in the kidney with the gauze and to use few or no sutures. This is especially desirable since the harmful effects of sutures upon the renal cortex is common knowledge.

We have found it also very helpful in controlling the persistent oozing of blood from adhesions following nephrectomy and the muscles which are necessarily incised in making a renal incision. On two occasions we have used it with gratifying results

to pack the bed of the prostate following a suprapubic enucleation.

While our experience with the gauze has been limited strictly to the field of urology, its advantages in general surgery are obviously manifold. With the aid of the gauze we can imagine that one could easily resect a part of the liver or spleen or pancreas without the usual fear of uncontrollable hemorrhage. It would seem quite feasible to pack a ruptured kidney or spleen to control bleeding that otherwise might make the removal of these organs necessary. It might be possible to administer the gauze by mouth to control gastric hemorrhage provided, of course, the medium in the stomach was rendered slightly alkaline—certainly there could be little danger from using it in this manner.

J. Z. McDANIEL, M.D.

J. C. KEATON, M.D.

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#### A.M.A. JOINS WORLD MEDICAL ASSOCIATION.

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*Closer International Ties to Be Established to Promote Interchange of Information And Assist in Health Education*

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The American Medical Association, by action of the Board of Trustees at its last meeting, has become a member of the "World Medical Association"—an organization which will promote the interchange of medical information among the medical associations of the world, according to an editorial in the October 26 issue of *The Journal*.

The editorial follows in full:

"At the end of September a conference met in London in which there were medical representatives of twenty-one European countries and ten countries outside Europe and at which the American Medical Association was represented by several observers appointed by the Board of Trustees. The meeting was held under the joint auspices of the British Medical Association, whose president, Sir Hugh Lett, presided, and the Association Professionnelle Internationale des Médecins. The latter organization was an assemblage which was constituted before the war to give opportunity for interchange of medical information among the medical associations of the world regarding mutually interesting problems. The new conference agreed unanimously that an in-

ternational organization of medical associations should be established and should limit itself to matters of medical practice and social medicine. The French, Belgian, Greek and Dutch delegates indicated that every country had its academies for promotion of medical science and that the immediate need was for an organization to defend the rights of the ordinary practitioner, especially in view of legislation passed in many countries. Dr. T. C. Routley, representing the Canadian Medical Association, indicated the desirability of an agency whereby the World Health Organization and UNESCO could make contacts with the medical associations of various countries. Ultimately the following platform was adopted for the new World Medical Association:

"To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available in order to assist all peoples of the world to attain the highest possible level of health; to study the professional problems which confront the profession; to organize an exchange of information on matters of interest to the profession, and to establish relations with, and to present the views of the medical profession to, the World Health Organization and the United Nations Educational, Scientific and Cultural Organization.

"The members of the World Medical Association will be international medical associations representative of the medical profession in the country concerned. A subscription was fixed at 10 Swiss centimes per member for each national group up to a total of 10,000 members and 5 centimes per member above the first 10,000, with a maximum for any member association of 1,500 Swiss francs. Each member association will have two seats on the governing body. A professional committee of nine was established to draft a constitution and by-laws in French and in English to be submitted to the next conference, to be held in Paris. There are to be two secretaries for the World Medical Association, one in London and one in Paris. The American Medical Association, by action of the Board of Trustees at its last meeting, became a member of this organization."

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#### SCIENTIFIC EXHIBIT

*Centennial Session—American Medical Association*

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At the Centennial Session of the American Medical Association to be held in Atlantic City, June 9 to 13, 1947, the Scientific Exhibit will include both the history of medicine during the past century and the latest developments of medical science.

Application blanks for space are now available. All applicants must fill out the regular form. Applications close on January 13, 1947, after which time the Committee on Scientific Exhibit will make its decision and notify the applicants.

Application blanks for space should be procured as soon as possible. They are available from The Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.



## WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

The meeting of the Advisory Committee with the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia, was held at the Academy of Medicine in Atlanta, August 28, 1946.

The meeting was called to order by Dr. Eustace A. Allen, chairman of the Advisory Committee, who welcomed the advisory members and board members present at the meeting.

Dr. Allen advised that the Auxiliary should strive: (1) to increase its membership; (2) to carry the gospel of medicine to the people; and (3) to advance education in public health.

Mrs. Schaefer, president of the Auxiliary to the Medical Association of Georgia, presented these plans for the year.

### THEME: FOUR "B's"

Be friendly—Be informed—Be courageous—Be united.

#### *Objectives:*

1. Enlist the interest of every doctor's wife in Auxiliary work, thereby developing an effective Woman's Auxiliary to the Medical Association of Georgia.
2. Educate ourselves as to the nature of the ideas, ethics and standards upon which medicine is operated.
3. An active public relations, health and legislative committee in each county auxiliary.
4. A lay program depicting What Medicine Has Done, What It Is Doing, and What It Will Do in the Future (health education).
5. Promote the work of public health.
6. Each county auxiliary to have reciprocity meetings with other women's organizations.
7. Promote Hygeia and subscribe to *The Bulletin*, official journal of the Woman's Auxiliary to the A.M.A.

Each objective was discussed individually. Dr.

Allen moved, and it was approved, that the advisory board accept the objectives and offer co-operation in carrying them through.

Plans of each committee chairman were presented and discussed.

Mrs. John Elliott, of Savannah, chairman of legislation, gave a very interesting outline of legislative plans, which was received with enthusiasm from the entire assemblage and heartily endorsed. Her plan was called "The Savannah Plan." It was moved to publish her report in the next issue of the Georgia Medical Journal.

Mrs. C. W. Roberts suggested that we have a speakers' bureau, from which to draw speakers against political or socialized medicine.

Dr. Lunsford spoke on public health, and the Hill-Burton bill.

The discussion of payment of dues by doctors' widows was brought up and it was advised that it be left with each auxiliary as to the payment of dues and the holding of office by doctors' widows.

There being no further business, the meeting was adjourned, after which Mrs. Schaefer entertained at a delightful tea in the dining room.

Respectfully submitted,

IRMA D. FOWLER,  
(Mrs. Ralph Fowler)  
*Recording Secretary.*

\* \* \*

Mrs. William L. Ballenger, Sr., wife of Dr. Ballenger and a leader in the civic and religious life of Atlanta, died September 23.

\* \* \*

The Floyd County Auxiliary is heartily congratulated upon its reorganization on October 15. The following officers were elected:

President, Mrs. Raiden Dellinger; Vice-President, Mrs. Lee Battle; Secretary, Mrs. Ralph McCord; Treasurer, Mrs. Ralph Davis.

## GEORGIA DEPARTMENT OF PUBLIC HEALTH

## PUBLIC HEALTH AND INDUSTRY

The function of any industrial plant is to produce, and in any plant production will be dependent on two factors; namely, manpower and machines. The maintenance of machines is an important consideration and comes through such items as lubrication, repairs, installation, and the like. The maintenance of manpower, on the other hand, can come only through the approach of industrial health. Both manpower and machines must be in their highest state of productive ability, otherwise a maximum output of finished goods will not be obtained.

The medical program of any industry is the mechanical device provided to insure the maximum productive ability of manpower. Such a medical program must be practical in its application to the average plant employee group and must be capable of being fitted into the budgetary requirements as to be a profitable adjunct to the general plant organization.

The functions of such plant programs may be diverse. Many times they are limited primarily to first aid and allied work. Where such an approach is taken, no consideration is given to the preventive aspects, but rather emphasis is placed on caring for the worker after injury or disability has occurred.

There is no question that it costs less to prevent accidents and illnesses than it does to pay for these disabilities after they have occurred. In considering medical policies and facilities for a plant program, it is desirable that consideration be given to designing a program along the lines of prevention as well as direct treatment.

Figures indicate that of all industrial absenteeism, roughly 10 per cent is due to direct occupational diseases, accidents, and illnesses; and the remaining 90 per cent is to due to diseases to which the community population falls heir. From these statistics it is obvious that the program which will accomplish a reduction in the 90 per cent due to non-occupational absenteeism will do much toward lowering the overall absenteeism of the industrial group. There are selected features of an industrial program which do much to prevent absenteeism from non-occupational causes.

Physical examinations play an important part in an industrial program. These may include three types: (1) Pre-placement; (2) Periodic, and (3) Special. The pre-placement examination is applied to the individual at the time of employment. The principal function of this examination is not to determine whether or not a man is to be employed, but rather to assay the physical ability of the individual, his limitations, handicaps and the like, and to determine the best type of job to which he might be assigned. The proper use of this tool will give information of considerable value to the operating department

of any plant and will result in a more intelligent placement of the worker. The pre-placement examination will also serve to reveal disabilities which might have resulted from previous employment when compensation might become a factor.

Once an individual is employed it does not mean that his physical status will remain the same thereafter. Like the mechanical equipment in a plant, it is desirable periodically to take inventory of the working condition of the manpower. This can be accomplished through the periodic physical examination. The frequency for such examinations will be determined more or less by the type job involved. These examinations and other indicated examinations should include all personnel of the plant from the plant manager down the line. This is desirable from two standpoints: (1) It is more important that the administrative and executive personnel be kept in their best physical condition than it is for the average plant employee; (2) If the general employee group is aware of the fact that such examinations include management, they are more likely to react favorably toward such a program and will cooperate more readily.

The increasing use of toxic materials in plant processing has created a serious industrial health problem. Exposure to such materials makes it desirable for the individual worker to be examined by special procedures which are designed to reveal evidence of various types of industrial poisoning. In the case of continuous exposure to low concentrations of toxic materials, the damage may be gradually done and take place before either the individual or management realizes the significance. This special examination in many cases may serve as the only protection that a worker has where occupational exposures are present.

Often the industrial health program is the only method by which certain preventive or public health measures can be brought to selected groups of the adult population. With comparatively little effort and responsibility on the part of the plant physician, advantage may be taken of existing community programs for the prevention of major communicable diseases.

Statistics in Georgia indicate a tuberculosis rate occurring in the industrial population of roughly 15 per 1,000, which means that the average plant employing 1,000 persons can expect to have about 15 significant cases of tuberculosis in its population. The only way of screening out these cases is by application of the chest x-ray to the entire worker group. The purpose of such an industrial program is not to prevent these individuals from receiving employment, but rather it is to aid them in the discovery of the disease and assist in obtaining the necessary treatment. It also serves to remove infected individuals, thus reducing the number of new



cases which would normally come from these contacts.

Industry in general is coming to realize the relationship between venereal disease, industrial efficiency, and hidden costs. Many times workers with early symptoms of syphilis are psychologically as well as physically disturbed and their resulting work is usually of poor quality. Minor numbers of individual occurrences of this type, multiplied by many cases, soon result in a substantial loss to industrial production.

A necessary part of any attempt to control venereal diseases in the industrial group is the matter of education. The educational approach should be directed both toward management and labor. Management must come to realize that not all syphilitics are infectious, and also that infectious cases may be rendered non-infectious by proper treatment. Such employees are not bad industrial risks and should not prove expensive in cost of medical care or early retirement provided proper treatment is administered. With the worker, facts concerning venereal diseases and sources of infection along with medical treatment should be stressed. The responsibility for the control of venereal diseases rests jointly with management, the employee, and the community. Where venereal disease programs are inaugurated by the management, advantage should be taken of the facilities available through official organizations such as state departments of health or existing local agencies.

It has often been said that an army marches on its stomach. The same is certainly true of an industrial group in that the fuel furnished to the worker's body will to a considerable extent govern his physical energies. For this reason it is desirable for the general medical plan of a plant to consider the matter of nutritional status of the employee group. This does not mean that every plant should attempt to provide industrial feeding facilities, although with many larger plants this proves to be a profitable investment. In any plant the opportunity exists for educational work in teaching the employees what type of food they should eat and also what part food plays in their general health and ability to work.

The general working environment exerts a powerful influence on the health of the employee. The use of toxic materials in plant processing is limited only by the ingenuity of the chemist. More and more these materials are used in industry. They constitute a widespread and critical health problem which any plant medical program can ill afford to overlook.

Since the plant physician has responsibility for the maintenance of manpower in his industrial organization, he should certainly know something of the operations which are carried out in the plant and materials which are used in processing. Too frequently the physician charged with this responsibility has little knowledge of the environment and the potential or actual haz-

ard created by exposure to toxic materials. It is impracticable and impossible for plant medical personnel to become expert industrial hygienists, but they should be sufficiently familiar with processing materials to realize the potential problems. They should also be willing to seek the advice and assistance of men scientifically trained in this field. Such assistance is readily available to any plant in Georgia through the Department of Public Health.

The evaluation of such occupational exposures can come only through a detailed industrial hygiene study which includes methods of processing, types of materials employed, job analyses, collection and determination of atmospheric and other samples, etc.

In planning and carrying out a broad program of industrial health the efforts of all agencies concerned should be coordinated by the plant physician. This includes cooperation with the plant engineering department relative to environmental problems, and also includes any participation by officials in bringing to the plant assistance in matters of public health and preventive medicine.

N. E. HENDRICKS, Ch.E.

#### STREPTOMYCIN FOUND EFFECTIVE IN MILD INFLUENZAL MENINGITIS

A highly fatal disease—influenzal meningitis—is yielding to the therapeutic power of streptomycin.

Four medical investigators, writing in the October 26 issue of *The Journal of the American Medical Association*, state that complete recovery is possible when this new antibiotic drug is used in cases of average severity.

A total of 25 patients were studied at the Babies Hospital and the Department of Pediatrics, Columbia University College of Physicians and Surgeons by Hattie E. Alexander, M.D., and Grace Leidy of New York, and at the Squibb Institute for Medical Research by Geoffrey Rake, M.B., B.S., and Richard Donovan, Ph.D., of New Brunswick, N. J.

Influenzal meningitis is an inflammation of the meningeal membrane which forms the tender lining of the spinal cord. This disease which is caused by a bacillus should not be confused with true influenza, which is a virus infection.

Twelve patients whose infections were mild or moderately severe recovered promptly and completely after treatment with streptomycin. The duration of infection prior to streptomycin treatment was less than eight days in all cases.

The other 13 patients, the majority of whom had the severe form of the infection, received rabbit antiserum, sulfadiazine and streptomycin. Three of the patients with the severe chronic form of the disease died.

The investigators point out that "in the severe infections the results suggest that therapeutic failure will be reduced to a minimum by the initial use of all three agents, i. e., rabbit antiserum, sulfadiazine and streptomycin."

Speaking of the 22 patients who survived, the authors state that "although it is appreciated that the increase of survivals in this group may increase the incidence of mentally defective children, this therapeutic program must be given a trial until it is demonstrated that all the patients who recover from such infections show severe permanent mental deterioration."

**The Medical Association of Georgia will hold its next annual meeting at the Bon Air Hotel, Augusta, April 22-25, 1947.**

## GEORGIA STATE NURSES' ASSOCIATION



Exhibit on Student Nurse Enrollment for Georgia as seen at the Third Southwide Georgia Citizens Conference held October 14-15, at the Biltmore Hotel, Atlanta.

Left to right are, Mrs. Durice D. Hanson, R.N., Executive Secretary, Georgia State Nurses' Association; Mrs. Bruce Schaefer, of Toccoa, President, Woman's Auxiliary to the Medical Association of Georgia, and Dr. Ralph Chaney, of Augusta, President, Medical Association of Georgia.

An intensive program for Student Nurse Enrollment is being sponsored by these groups in cooperation with the Georgia Federation of Women's Clubs and others. Contests on nursing essays, career books and poster contests are being sponsored throughout Georgia in an effort to better publicize the program of nursing education and the great opportunities offered in this field.

## THE BIENNIAL CONVENTION OF THE AMERICAN NURSES ASSOCIATION

MRS. OLIVE L. BARBIN, R.N.  
*President, Georgia State Nurses' Association*

The American Nurses' Association, the National Organization for Public Health Nursing, and the National League of Nursing Education met in joint convention in Atlantic City, N. J., Sept. 23-27, 1946. Georgia was represented by its largest delegation since 1940, with 47 graduates and two student nurses in attendance.

Topics for discussion revolved around the theme, "Nursing in the Nation's Plan for Health." The content of the program reflected a recognition on the part of the nursing profession that events of the years of war and the difficult struggle for peace have had a profound influence on

this group. Evident also was the fact that, as a group, nurses are aware of a compelling responsibility facing their profession in the field of health.

The realization that the nursing profession could not, without revision of organization, successfully meet this responsibility to its members and to the nation was most forcefully pointed out in the report on the structure of organized nursing by Raymond Rich Associates. This report is the result of an exhaustive six-year study of the present organization of the six national nursing groups and their relation to one another and to the public.

Two new structural plans were submitted, either of which, if adopted, would merge the existing national nursing organizations into one group and bring into the membership lay persons interested in the advancement of nursing. The chief difference in the two plans is the degree to



which non-nurse members are allowed participation. The House of Delegates voted that a detailed analysis of the study be made and made plans for further consideration of the plans before another biennial meeting. In the meantime work of the American Nurses Association will go forward without regard to future changes.

After much heated and emotional discussion, it was voted by the House of Delegates that qualified Negro graduate nurses, who cannot become members through their state associations, be admitted to the American Nurses Association by individual membership. Since the by-laws make no provision for such membership, this action cannot be implemented at least until another convention, and the question which has come up for many years in succession was referred to the A.N.A. board of directors.

A socio-economic study of nursing is to be made, beginning in November, by the Federated Bureau of Labor Statistics, at the request of the National Nursing Council. This should provide valuable information to state and district nurses' associations in their planning to improve employment conditions for nurses, for it was decided that these groups are qualified to act, and should act exclusively for their respective memberships in this important field. A forty-hour week with no decrease in remuneration is urged for nurses, though it is realized that many obstacles must be removed before this is a possibility.

Proposed legislation affecting nursing was considered and recommendations from the A.N.A. Committee to Outline a Definite Program on State and Federal Legislation were accepted. Most of the recommendations are already in effect in Georgia because of the good work done by a wide awake legislative committee. Dr. Joseph S. Lawrence, Director, Office of Federal Health Measures, spoke on some measures that have passed and some that have not. He suggested that since this legislation will have a profound effect upon nurses and nursing that nurses become well informed, and as occasion arises discuss with the patient what care he may receive under a government care plan.

Dr. Michael Davis, Executive Secretary, Committee for Nation's Health, spoke on *Prepayment Plans for Health*, a major feature of the health program presented by President Truman last November and incorporated in bills sent to the Congress. Here again nursing would be definitely affected.

Messages from President Truman and from many state governors were read. Among them was one from Georgia's Governor Ellis Arnall in which he expressed his faith in nurses to promote a better program of health for the nation.

Among the participants at a panel discussion on, "Who Shall Pay for Nursing Education?" were Miss Ruth Sleeper, R.N., president of the National League of Nursing Education, A. J.

Brumbaugh, Ph.D., American Council of Education, and U. S. Senator Claude Pepper. It was the consensus of opinion that the public and the patient must pay for nursing education if high quality nursing care is to be provided for our people. Senator Pepper stated, "Nursing schools must be divorced from the hospital system to which they are attached and raised to a college level."

#### NEWS ITEMS

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, October 1. Dr. W. A. Newman was in charge of the program.

Dr. Paul B. Beeson, Atlanta, member of the Emory University School of Medicine faculty since 1942, has been appointed chairman of the department of medicine. Dr. R. Hugh Wood, medical school dean, announced recently. Dr. Beeson is widely known as a research scientist. He is now conducting a special project in the study of fever under a \$12,500 grant from the United States Public Health Service.

Dr. A. G. Bell, native of Swainsboro, recently discharged from the Medical Corps of the U. S. Navy, has opened offices at Wrightsville for the practice of medicine.

Dr. Marion T. Benson, Sr., and Dr. Marion T. Benson, Jr., Atlanta, announce the removal of their offices from the Medical Arts Building to 704 Piedmont Avenue, N. E., Atlanta. Practice limited to obstetrics and gynecology.

Dr. C. I. Bryans, Jr., formerly of Augusta and the U. S. Army Medical Corps, announces the opening of offices at Baxley for the practice of medicine. Dr. Bryans is associated with Dr. J. T. Holt.

Dr. James H. Crawford, of Atlanta and Marietta, is spending most of his time at his country home on the road leading off Bell's Ferry road to Kennesaw.

Dr. W. P. Downey, Tallapoosa, after five years' service in the Medical Corps of the U. S. Navy, has resumed his practice of medicine at Tallapoosa.

The Crawford W. Long Memorial Hospital staff dinner meeting was held in the hospital dining room, Atlanta, October 10. The following program was presented: "Avitaminosis, Severe", discussion led by Dr. Lamont Henry. "Diarrhea of Undetermined Origin", discussion led by Dr. W. L. Thomason and Dr. Hal Davison.

Dr. William C. Calhoun, formerly of Macon, announces his release from the Marine Corps and is now associated with Dr. T. J. Ferrell, Waycross. Practice limited to surgery and obstetrics.

Dr. Allen W. Coward, Savannah, recently released from the U. S. Army Medical Corps, has been appointed physician of the Savannah Division of the University of Georgia at Hunter Field, as recently announced by Dr. Glenn W. Sutton director of the division.

Dr. A. D. Duggan, Sandersville, left recently for the Mayo Clinic, Rochester, Minn., to resume his studies in neurologic surgery under a fellowship offered by the clinic. Dr. Duggan was recently released from active duty with the U. S. Navy and has been associated with Rawlings' Sanitarium, Sandersville.

Dr. Edgar M. Dunstan, Atlanta, having returned from active service in Army of the United States, announces his association with Dr. Mason I. Lowance, Dr. Eugenia

C. Jones and Dr. Warren B. Matthews of the Lowance Clinic, suite 215 Doctors Building, 478 Peachtree Street, N. E., Atlanta. Practice limited to internal medicine, allergy, cardiology and pathology.

The Eighth District Medical Society held its semi-annual meeting at the Sea Island Casino, Brunswick, October 15. The Glynn County Medical Society was host. Program: Meeting called to order by Dr. J. A. Leaphart, Jesup, president; Invocation, Rev. Brooks H. Wester, Brunswick; Address of Welcome, Dr. W. C. Thomas, Brunswick; Response to Address of Welcome, Dr. Dan Jardine, Douglas. Scientific program: "Recent Advances in the Treatment of Vaginitis," Dr. R. L. Stump, Jr., Valdosta; "Tuberculosis," Dr. Rufus Payne, superintendent, Battey General Hospital, Rome; "Factors Concerned in Lowering Mortality in War Wounds," Drs. T. J. Ferrell and W. C. Calhoun, Waycross; Address, Dr. Ralph H. Chaney, Augusta, president of the Medical Association of Georgia; "Roentgen Findings in Non-Tuberculous Diseases of the Lungs," Dr. F. G. Eldridge, Valdosta. Business Session, Election of Officers and Adjournment. Officers: President, Dr. J. A. Leaphart, Jesup; Vice-President, Dr. W. W. Turner, Nashville; Secretary, Dr. G. T. Crozier, Valdosta.

The Eighth District Woman's Auxiliary to the Eighth District Medical Society met at the Cloister Hotel, Sea Island, October 15. Meeting called to order by Mrs. J. R. Gay, Waycross, president; Invocation and Words of Welcome, Mrs. H. J. Johnston, Brunswick; Response, Mrs. A. W. DeLoach, Waycross; Piano Solo, Reid Harris, Brunswick; Address, Dr. Ralph H. Chaney, Augusta, president of the Medical Association of Georgia; Business Session. Objectives of 1946-47, Mrs. Haywood Moore, Brunswick. Officers: Mrs. J. R. Gay, Waycross, president; Mrs. Bennett Owens, Valdosta, vice-president and Mrs. W. M. Flanagan, Waycross, secretary.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, October 8. Program: General Discussion of Veterans' Memorial Hospital in Savannah.

Dr. Charles G. Green, Waynesboro, recently released from the First Marine Division, has opened offices at Waynesboro for the general practice of medicine.

The Georgia Baptist Hospital staff dinner meeting was held in the Nurses' Home Dining Room and Sheffield Clinic, Atlanta, October 15.

The Forty-Third Annual Congress on Medical Education and Licensure will be held at the Palmer House, Chicago, Feb. 11, 1947.

Dr. Milford B. Hatcher, Macon surgeon, was recently elected a senior fellow of the Southeastern Surgical Congress at a meeting of the executive council of the Surgical Congress in Atlanta. On returning to civilian life he limited his practice to surgery. Recently he was chosen as assistant director of the cancer clinic at the Macon Hospital, Macon.

Dr. Forrest C. Hunter, former director of Piedmont Medical Center, Augusta, has joined the University of Georgia School of Medicine staff as head of the dermatology and syphilology department, according to Dr. G. Lombard Kelly, dean.

Dr. J. F. Johnson and Dr. Henry M. Lee, recently released from the Medical Corps of the U. S. Army, opened offices for the practice of medicine at Hamilton.

Dr. W. K. Kerr, a native of Abbeville, S. C., recently released from the Medical Corps of the U. S. Army, announces his association for the practice of general medicine with Dr. W. A. Mendenhall, Chamblee.

Dr. William H. Kiser, Jr., Atlanta, announces his return from military service and the reopening of his

office at 33 Ponce de Leon Ave., N. E., Atlanta. Practice limited to pediatrics.

Dr. Harold Long, Eastman, announces his release from military service and the re-opening of offices in the Doctors Building at Coleman Memorial Hospital, Eastman, for the practice of medicine.

Dr. James B. Martin, a native of Shellman, announces the opening of offices for the practice of medicine, Edison. Dr. Martin is the brother of Dr. Robert Martin, Cuthbert, and Dr. Walter Martin, Shellman.

Dr. Fredric R. Minnich, Atlanta, announces the association of Dr. William C. Helms in the practice of obstetrics and gynecology, 478 Peachtree Street, N. E., Atlanta.

Dr. Jack Clayton Norris, Atlanta, was notified on September 10 by the Navy Department that he had received the second Navy Unit Citation, which had been given to the U.S.S. Solace for outstanding performance of duty during the battle of Pearl Harbor on Dec. 7, 1941.

On September 26 Dr. Norris received another citation, the Bronze Star. The latter medal was for duty performed while a member of the medical staff aboard the U. S. S. Bountiful. This ship was in the supporting forces during the battles of Saipan, Guam, Iwo Jima, Philippine and Okinawa invasions. During a period of seventeen months the ship travelled more than 65,000 miles and its staff treated thousands of wounded sailors, marines and soldiers, with one of the lowest mortality rates in the history of warfare.

During the tour of duty Dr. Norris was a commander in the Medical Corps and was chief of the division of pathology and assistant senior medical officer. Dr. Norris was discharged to inactive duty on May 1 while at the Brooklyn Naval Hospital. He was promoted to a captain in November 1945. At present he is again practicing medicine in Atlanta after an absence of five years.

Dr. R. C. Pendergrass, Americus, widely known roentgenotherapist and head of the department of radiology at the Phoebe-Hutney Hospital in Albany, will continue to make his home and to maintain his offices and laboratories in Americus, spending Monday, Wednesday and Friday in Albany.

Dr. Ben S. Read, Atlanta, announces the removal of his offices to 110 Medical Arts Building, Atlanta. Gynecology and obstetrics.

Dr. Robert L. Robinson, who served for more than five years in the Southwest Pacific and for the past year at Lawson General Hospital, announces the opening of his office at 3041 Bolling Way, Atlanta, for the general practice of medicine and surgery.

Dr. Virgil P. Sydenstricker, professor of medicine at the University of Georgia School of Medicine, Augusta, has been notified by the British Embassy in Washington, D. C., that an award of the King's Medal has been made to him by King George VI of Great Britain in recognition of services rendered to the British Government during the war.

The letter dated October 1 and signed by H. R. F. Brett, of the honours and awards section, says:

"This embassy has been informed by the Foreign Office that the King has been pleased to award you His Majesty's Medal for service in the cause of freedom.

"Lord Iverchapel, the ambassador, has asked me to convey to you his personal congratulations on this well-merited award.

"Owing to the shortage of metal in the United Kingdom, some time will elapse before the insignia of your decoration can be sent, but arrangements are being made for the ribbon to be presented to you in the near future by His Majesty's consul at Atlanta, who will be communicating with you shortly."

Dr. Sydenstricker was in England a year during 1942-1943 and part of 1945. At that time he was con-



sultant to the British Ministry of Health in planning Britain's war rationing program.

He was also awarded the Campbell Lecture medal, conferred by the Queen's University at Belfast, Ireland, in recognition of the excellence of a series of lectures given at Queen's University during 1942. The lecture medal award was made earlier than that of the King's Medal. Dr. Sydenstricker also received some time back a citation of honor from the Dutch Government for services rendered to the Dutch during the war.

Dr. Jules Victor, Jr., Savannah, recently released from the U. S. Navy Medical Corps after four years of service, will resume the practice of internal medicine at 126 East Taylor Street, Savannah.

Dr. J. W. Williams, Jr., a native of Baldwin, was recently released from the U. S. Marine Corps and has opened offices for the practice of medicine in the Health Clinic, Lavonia.

The Georgia Medical Society held its regular meeting in the society's hall, 612 Drayton Street, Savannah, October 22. Program: "Paper on Regional Ileitis," Dr. Ralph Hill Chaney, Augusta, president of the Medical Association of Georgia.

The Second District Medical Society met at the Legion Home, Tifton, October 10. Call to order by the president, Dr. Chas. E. Zimmerman, Tifton; reading of minutes, announcements and introduction of visitors. Program: "Low Back Pain," Dr. Thomas P. Goodwyn, Atlanta; "Abnormal Uterine Bleeding," Dr. Kirk Shepard, Thomasville; "Childhood or Primary Tuberculosis," Dr. R. M. Joiner, Moultrie; "Experience With Oxidizable Gauze," Dr. J. Z. McDaniel, Albany. Officers: Dr. C. E. Zimmerman, Tifton, president; Dr. George L. Epps, Bainbridge, vice-president; Dr. J. C. Brim, Pelham, secretary-treasurer. The next meeting of the Second District Medical Society will be held at Bainbridge April 10, 1947. Those selected to present papers at that time are: Dr. R. C. Jones, Tifton, Obstetrics; Dr. Barry Bowman, Albany, Surgery; and Dr. M. B. Wise, Thomasville, Allergies.

Dr. William N. Etheridge, Atlanta, announces the opening of his office at 517 First National Bank Building, Atlanta. Practice limited to urology.

Dr. Ralph Hill Chaney, Augusta, president of the Medical Association of Georgia, addressed the Woman's Auxiliary to the Richmond County Medical Society, Augusta, October 22. Dr. Chaney's subject was "Medical Legislation."

Dr. C. F. Holton, Savannah, chief surgeon of the Central of Georgia Railway, presided at the meeting of surgeons associated with the hospital department of the Central of Georgia Railway held at the Hotel Tybee, Savannah Beach, September 21 and 22. Dr. Holton led the round table open forum meeting at which problems of the industrial surgeon were fully discussed by the surgeons associated with him.

The Sumter County Medical Society held its monthly meeting at the Windsor Hotel, Americus, September 5. Dr. A. C. Primrose, Americus, president, presided at the meeting and Dr. T. Schley Gatewood, Americus, had charge of the following program: "Refrigeration Anesthesia," Dr. Milford Hatcher, Macon; "The Role of Anomalies and Surgical Conditions of the Urinary Tract," Dr. Robert McAllister, Macon; Dr. H. A. Smith, Americus, gave a case report on "Pyloric Stenosis." Visiting doctors included: Dr. Steve P. Kenyon, Dawson, president-elect of the Medical Association of Georgia; Dr. J. C. Tidmore, Dawson; Dr. J. C. Patterson, Dr.

W. C. Elliott, both of Cuthbert; Dr. J. C. Keaton, Dr. J. Z. McDaniel, Albany; Dr. W. V. Roberts, Lumpkin; Dr. Frank Snelling, Augusta; Dr. E. F. Seay, Marshallville; Dr. Thos. M. Adams, Dr. C. P. Savage, Montezuma; Dr. Lee Williams, Cordele; and Dr. J. L. Gallemore, Perry. About 30 persons attended the dinner and meeting.

The Ware County Medical Society met at the home of Dr. and Mrs. Leo Smith and Dr. and Mrs. W. L. Pomeroy, Waycross, September 5. Program: "Head Injuries," Dr. Ansley Seaman, Waycross; discussion by Dr. W. L. Pomeroy, Dr. Kenneth McCullough, Dr. W. P. Stoner, Dr. T. J. Ferrell, Dr. Lewis Oden, Jr., Dr. B. E. Collins and Dr. B. H. Minchew. The society named Dr. B. H. Minchew, Dr. W. F. Reavis and Dr. L. W. Pierce as the committee to prepare resolutions on the death of Dr. Paul K. McGee. The following physicians were present: Dr. D. M. Bradley, Dr. B. R. Bussell, Dr. J. E. Penland, Dr. W. M. Flanagan, Dr. Ansley Seaman, Dr. William Hendry, Dr. Catherine McMillan Hendry, Dr. E. D. Hendry, Dr. B. H. Minchew, Dr. B. E. Collins, Dr. L. W. Pierce, Dr. Kenneth McCullough, Dr. W. D. Mixson, Dr. Lewis Oden, Jr., Dr. Floyd E. Davis, Dr. A. W. DeLoach, Dr. W. C. Calhoun, Dr. J. R. Gay, Dr. Jack Cannon, Dr. J. H. Brewton, Dr. H. W. Muecke, Dr. T. J. Ferrell, Dr. W. F. Reavis, Dr. Ed Roe Stamps, Dr. W. P. Stoner, Dr. Joe M. Jackson, Dr. W. L. Pomeroy and Dr. Leo Smith.

First annual meeting of the Georgia Chapter of the American College of Surgeons and the fall meeting of the Fifth District Medical Society were held jointly at the Academy of Medicine, Atlanta, October 31. Operative clinics were held at the following hospitals: Crawford W. Long, Georgia Baptist, Grady, Emory University, Piedmont, Scottish Rite, Ponce de Leon Infirmary, and St. Joseph's Infirmary. Evening session with dinner at the Academy of Medicine. Presiding Dr. F. P. Calhoun, Atlanta, vice-president-elect American College of Surgeons; Dr. E. A. Bancker, Atlanta, president Fifth District Medical Society; Dr. C. F. Holton, Savannah, chairman, Georgia Chapter of the American College of Surgeons. Dr. Ralph H. Chaney, Augusta, president of the Medical Association of Georgia, Remarks. "Congestive Heart Failure," Dr. Eugene A. Stead, Jr., Atlanta, Emory University School of Medicine; "The Management of Lesions of the Stomach, Duodenum and Jejunum," Dr. Frank H. Lahey, Lahey Clinic, Boston.

State officers of the Georgia Chapter of the American College of Surgeons: Dr. C. F. Holton, Savannah, chairman; Dr. Grady N. Coker, Canton, vice-chairman; Dr. M. T. Harrison, Atlanta, secretary; Dr. W. W. Baxley, Macon, council; Dr. W. Bruce Schaefer, Toccoa, council.

Fifth District Medical Society officers: President, Dr. E. A. Bancker, Atlanta; Vice-President, Dr. T. Sterling Claiborne, Atlanta; Secretary-Treasurer, Dr. L. Minor Blackford, Atlanta; Councilor, Dr. Marion T. Pruitt, Atlanta; Vice-Councilor, Dr. Spencer A. Kirkland, Atlanta.

Woman's Auxiliary to the Fifth District Medical Society officers: Mrs. B. L. Shackleford, Atlanta, president; Mrs. H. C. Crawford, Atlanta, vice-president; Mrs. Ben H. Clifton, Atlanta, secretary; Mrs. Mason Lowance, Atlanta, publicity chairman; Mrs. Christopher J. McLoughlin, Atlanta, scrapbook chairman; Mrs. George W. Fuller, Atlanta, chairman, dinner committee; Mrs. T. C. Davison, Atlanta, co-chairman.

Dr. Charles A. Eberhart, Atlanta, announces the removal of his offices from the Medical Arts Building to 704 Piedmont Avenue, N. E., Atlanta. Practice limited to urology.

Dr. Jack H. Pritchett, Jr., Bremen, recently released from the U. S. Public Health Service, having served in the Pacific area, announces his association with Dr. O. D.

King and Dr. H. D. Allen, Bremen Hospital, Bremen, for the practice of medicine and surgery. Dr. Pritchett also has opened offices at Buchanan, where he spends several hours each day.

The Georgia Association of Pathologists resumed its meetings in October following a temporary discontinuance on account of the war when a number of its members were in active service. This association was organized some ten years ago by Dr. Everett L. Bishop, who was its first president, and at the recent meeting he was again elected president with Dr. Sidney C. Madden as secretary. All pathologists in the State are members of this association. Periodic meetings will be held in Atlanta and also in other cities at the time of the meeting of the Medical Association of Georgia.

### OBITUARY

*Dr. David G. Elder*, aged 82, practicing physician in the Chickamauga territory for more than 60 years, died at his Chickamauga home, Sept. 7, 1946. Dr. Elder was a member of the well-known Henry and Elder families of Chattooga County, and was reared at Summerville. He graduated from Emory University School of Medicine, Atlanta, in 1886. He was a member of the Walker-Catoosa-Dade Counties Medical Society, the Medical Association of Georgia, a fellow of the American Medical Association, also a member of the Elizabeth Lee Memorial Methodist Church and a Mason. He is survived by his wife, the former Miss Effie Mitchell; two daughters, Mrs. T. H. Hunt and Mrs. B. F. Hall; one son, John G. Elder, all of Chickamauga; six grandchildren and two great grandsons. Funeral services were held from the Elizabeth Lee Memorial Methodist Church with the Rev. R. B. Hawkins and the Rev. C. E. Fite officiating. Burial was in the Chickamauga Cemetery, Chickamauga.

*Dr. Carl Clifton Garver*, aged 43, Atlanta surgeon who won fame for heroic action during the sinking of the cruiser U. S. S. Atlanta, was drowned when he apparently fell from his private boat enroute from Parris Island, S. C., to Jacksonville, Fla., Sept. 10, 1946. His body was found by a Marine search patrol two days later on the beach fronting the Broad River at Parris Island, S. C. Dr. Garver was born in Charleston, Ill., the son of Mr. and Mrs. J. P. Garver, who now live at Jacksonville, Fla. He graduated from Emory University School of Medicine, Atlanta, in 1932. In 1933, Dr. Garver was chief surgeon for the Georgia Power Company, a post he held until he went on active duty with the Navy in January, 1941. After a year of recruiting duty in Macon, he went to sea aboard the U. S. S. Atlanta and survived the sinking of the vessel in bitter sea action off Guadalcanal. Commander Garver saw duty aboard five more ships before his return to the United States. He was awarded the Presidential Unit Citation for service aboard the U. S. S. Atlanta. He also received a letter of commendation from Admiral William F. Halsey for zealous performance of duty under severe combat conditions.

Commander Garver was a member of the Fulton County Medical Society, the Medical Association of Georgia, and a fellow of the American Medical Association. Survivors include his wife, the former Miss Hortense Elton, Atlanta, and his parents, Mr. and Mrs. J. P. Garver, Jacksonville, Fla.

Funeral services were held at Sacred Heart Church, Atlanta, with Chaplain Thomas H. Reilly officiating. Burial was in the National Cemetery, Marietta.

*Dr. Trimble Clarence Johnson*, aged 52, Atlanta physician, died at his home after a long illness, October 6, 1946. A native of Atlanta, Dr. Johnson was the son of Dr. and Mrs. James Clarence Johnson. He was a grad-

uate of Peacock School for Boys, Marist College, attended the Staunton Military Academy in Virginia and Georgia Tech, and was graduated from Emory University School of Medicine, Atlanta, in 1918. After he interned in New Orleans Charity Hospital he joined the Navy and was attached to the Marine Corps as a lieutenant, junior grade. After discharge from the service, he entered private practice with his father, Dr. James Clarence Johnson, prominent Atlanta gastroenterologist.

He was a member of Phi Delta Theta, Phi Rho Sigma medical fraternity, and the honorary medical fraternity of Asklepios, the Fulton County Medical Society, the Medical Association of Georgia, the Fifth District Medical Society, the Southern Medical Association, the American Medical Association and was a fellow of the American College of Physicians.

Dr. Johnson was a member of St. Mark's Methodist Church, the Piedmont Driving Club and the Audubon Society of America.

Surviving are his wife, the former Miss Alice Anderson of Marietta; a daughter, Mrs. William N. Fessenden, Kingston, N. Y.; one son, James Trimble Johnson, Atlanta; his parents, Dr. and Mrs. James Clarence Johnson; his sister, Miss Laurian Miller Johnson; and his brother, Dr. McClaren Johnson; and several nieces and nephews, all of Atlanta.

Funeral services were held at Spring Hill, with Dr. Lester Rumble officiating.

Burial was in West View Cemetery, Atlanta. Pallbearers were Douglas Wright, W. W. Snow, Charles Marshall, Dr. Steve P. Kenyon, Dr. W. S. Dorrough, Dr. Hal Davison, Dr. John B. Duncan and Dr. W. W. Anderson. Members of the Fulton County Medical Society formed an honorary escort.

*Dr. Walter A. Rivers*, aged 79, Glenwood, died in a Dublin hospital, Sept. 28, 1946. Dr. Rivers graduated from Emory University School of Medicine, Atlanta, in 1894, and had practiced medicine in Glenwood for more than 52 years. Survivors are his wife; a son, R. Ernest Rivers, Atlanta; two brothers, H. D. Rivers and J. G. Rivers, both of Glenwood; a sister, Mrs. C. W. Arrington, Damascus; three grandchildren and four great-grandchildren. Funeral services were held at the Glenwood Baptist Church with the Rev. J. D. Rabun, the Rev. Thad Persons, the Rev. C. M. Ledbetter and the Rev. Guy Hutchenson officiating. Burial was in the Glenwood Cemetery, Glenwood.

**The Medical Association of Georgia will hold its next annual meeting at the Bon Air Hotel, Augusta, April 22-25, 1947.**

*The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.*

**OUR ADVERTISERS HAVE BEEN GRACIOUS IN THEIR SUPPORT OF THE JOURNAL PLEASE REMEMBER THEM WHEN PURCHASING YOUR SUPPLIES**



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### ONE YEAR'S EXPERIENCE WITH A MOBILE X-RAY UNIT

ABE J. DAVIS, M.D.

E. S. SANDERSON, M.D.

*Augusta*

It is common knowledge that the x-ray is the most satisfactory method of the present-day diagnosis of tuberculosis. Until the introduction of the so-called miniature films the use of x-ray as a method of screening large groups of population was impractical and prohibitive, because of the cost and slowness of the process. The value of miniature films has been amply proven during the war period, and the use of such is rapidly increasing as a means of case-finding in a tuberculosis control program.

In 1941 the Georgia State Department of Health listed Richmond County as having the highest tuberculosis mortality rate in the State. It was at this time that the Augusta-Richmond Tuberculosis Association voted to greatly enlarge its scope and appeal for public support to begin a program aimed at mass chest x-ray studies of the people of our community. The program was to be a joint one between the Tuberculosis Association and the Richmond County Health Department. Initial groundwork was laid by Dr. Clair A. Henderson and continued by his successor, Dr. Abe J. Davis.

In the beginning a survey of the situation showed these to be existing conditions:

The average death rate of tuberculosis for the past eight years had been 107 per

100,000, yet less than 200 cases of tuberculosis were known to the Health Department. Chest clinic facilities were limited to those of the Out-patient Department at the University School of Medicine, where the number of patients that could be seen was limited. A spot map of cases revealed that the incidence of tuberculosis was, as a rule, heaviest in areas noted for very poor housing, including both white and Negro districts. An analysis of the death certificates showed that, by numerical rank, the occupation of the dead tuberculous patient had been (1) housewife, (2) textile worker, (3) domestic servant, (4) laborer, (5) office worker and (6) food handler. Since there is naturally a housewife in every home in the county and since there are about twenty thousand households, the mortality rate among housewives was really extremely low, but in other cases the occupation gave a clue as to where to begin work.

Since the program was to begin with an intense case-finding campaign, to embrace and sponsor health education and follow-up of cases, and later hospitalization and quarantine of most of the cases, it naturally followed that it must be taken up and endorsed by the Richmond County Medical Society. This was done in principle. Civic organizations and the Central Labor Council of Augusta also endorsed the plan.

Funds were raised by pledges from a small group of interested business men who pledged over half the cost; by funds from the Scrap Metal Committee; by donations from clubs and individuals. Within a year funds were on hand and the order placed

From the Department of Bacteriology and Public Health, University of Georgia School of Medicine, and the Department of Health of Richmond County, Georgia.

Read before the Medical Association of Georgia, Macon, May 8, 1946.

for a mobile x-ray unit. Delivery was made about November 1, 1944, having been delayed by the exigencies of war. Although a few surveys were made, it was not until February 1945 that a full-time technician was available and routine operation begun.

The arrangement between the Health Department and the Tuberculosis Association was simple and satisfactory. The association has loaned the mobile unit to the health department for operation and maintenance. The association purchases all film needed as well as processing materials and equipment. It pays honorariums to specialists who interpret films. The Health Department houses the unit, provides personnel to operate it, supplies nursing and clerical help for organizing surveys, reporting and filing films, and sending out reports and doing nursing follow-up. It investigates all contacts of cases.

On January 1, 1946, a cooperative plan between the Medical School and the Health Department began to function. The essence of this plan is that every case admitted to the chest clinic at the school is first screened by the health department and only cases showing pathologic evidence are referred. The Health Department, at the same time, submits the 4x5 x-ray, a 14x17 picture, a history and reports on a tuberculin test, sputum test and serologic examinations. The Medical School, in turn, agrees to see every indigent patient referred to its clinic. The Health Department furnishes nursing service to the clinic.

The mechanics of taking 4x5 stereoscopic photofluorographs may be dismissed after saying that fifty patients an hour may be handled with ease, and that with a little timing it is unnecessary for the industrial worker to be away from his machine more than ten minutes.

The reporting is a matter that must be handled expeditiously and, at the same time, ethically. In every case the person to

be x-rayed must furnish the name of the physician to whom he wants the report sent before a picture is made. Should the picture be negative, a simple notice is sent by mail, in a sealed envelope, to the patient's home address. In the event of tuberculous disease or suspicion of such disease, an effort is made to obtain a larger picture. This is done, not because the smaller pictures are not unusually accurate but because a special stereoscopic view box is a necessary adjunct to their interpretation and because the physician is accustomed to reading conventional-sized films and often has equipment for viewing them. A tuberculin test is done, specimens of sputum and blood are sent to the laboratory and a history taken. All of these reports are mailed to the physician and at the same time a letter is mailed the patient saying that these reports have been sent to his doctor. The Health Department offers to the physician nursing follow up service. In cases where non-tuberculous disease has been noted, this information is immediately forwarded to the physician and the patient notified of our action.

Up until January 1, 1946 this unit had taken 8,585 pictures as outlined here:

	Positive for Tb.	Suspicious for Tb.	Non-Tb. Findings	Negative	Total	Per cent positive	Per cent suspicious
White males	27	69	67	2,882	3,045	0.88	2.26
White females	20	39	44	2,750	2,853	0.7	1.37
Total white	47	108	111	5,632	5,898	0.8	1.83
Colored males	1	20	68	1,075	1,164	0.09	1.72
Colored females	3	18	28	1,474	1,523	0.19	1.18
Total colored	4	38	96	2,549	2,687	0.15	1.45
Grand total	51	146	207	8,181	8,585	0.59	1.70

Included in this group are employees of textile mills, a kaolin mine, canning plant, newspaper printshop, banks, city fire and police departments, venereal disease patients at the out-patient department, medical students, all teachers and food handlers, high school and junior college students and visi-



tors to the local fair. All these pictures have been on volunteer groups except the food handlers and the school teachers, where it was compulsory by regulations of the Boards of Health and Education.

This first year has been the hardest. Since there was no person available who had experience with such a unit or such a program, progress was often made after a very cautious trial, often trial and error; bottlenecks appeared and had to be eliminated; personnel had to be indoctrinated with a set of inflexible rules; industry had to be assured that this was a service that the employees wanted and yet, we are proud to say, after the first four hundred films were made, there has not been a single unidentified film nor a mix-up of any kind. We do feel, however, that the scope of the work might be increased with additional clerical and nursing help.

The desire and intention is to expand this program, both in Augusta and in other communities. In a variety of ways the citizens of Augusta and Richmond County will be encouraged to avail themselves of x-ray service. This will include all persons in the 'teen age group, and above, who will make an appointment with the Health Department. It will be offered to industry as part of a pre-employment program. Housewives will be encouraged to demand it as a prerequisite for employment of a domestic servant. As in the past, demonstrations will be made for visitors from other communities.

With the continuation of such a program, and with the anticipated expansion of state hospital facilities, it is expected that tuberculosis in the Augusta area will cease to be a major health problem within a relatively short time. We truly believe that a community can purchase freedom from this plague if they are interested and are willing to pay the cost.

## PARATYPHOID B MENINGITIS IN AN INFANT

### *Report of Case*

LEONARD R. MASSENGALE, M.D.

*Augusta*

Holt and McIntosh list meningitis as a complication of *Salmonella* infections in general, with no specific reference to paratyphoid B meningitis.

In 1942 W. H. Patterson reported two cases of paratyphoid B meningitis with recovery following treatment with sulfapyridine and sulfadiazine. One of these cases he terms as being primary meningitis and the other as being secondary meningitis. He did not feel the sulfonamides given were specific for the disease.

In 1944 Teter reviewed the literature on *Salmonella* meningitides and found only eight authentic cases of paratyphoid B (*Salmonella* Schottmuelleri) meningitis.

The case we wish to report is of interest to us, not only because of its rarity but also because it presented such a diagnostic problem.

### REPORT OF CASE

This three-weeks-old Negro female was admitted to the University Hospital November 26, 1945. She was brought in by a public health nurse because of having frequent convulsions and vomiting for a week. There was no history of diarrhea, chill or apparent fever. There were fourteen siblings, eleven of whom are living and well. After a diagnosis was established in this case the Richmond County Public Department investigated the family, and stool culture on the infant's mother was positive for paratyphoid B bacillus (*Salmonella* Schottmuelleri). None of the rest of the family had positive stools or any history of a typhoid-like disease. The mother stated that she had what was diagnosed as typhoid fever some eighteen years ago. Birth was normal and spontaneous, occurring before the physician arrived at the home. The infant was given a formula consisting of evaporated milk and water, as the mother did not have any breast milk.

Examination showed a poorly developed, poorly nourished, markedly dehydrated Negro female three weeks of age, who was having repeated convulsions during which both arms and both legs jerked. The rectal temperature was 104.4° F. The skin was hot, dry and loose. The mucosa was of good color. There was no lym-

From the Department of Pediatrics of the University of Georgia School of Medicine, and the University Hospital, Augusta.

Read before the Medical Association of Georgia, Macon, May 8, 1946.

phadenopathy. The head was of normal shape, the anterior fontanel was sunken. The pupils were equal and reacted to light. Both ear drums were dull and not bulging. The nose was dry and both nares were patent. The tongue, gums and pharynx were negative. There was nothing abnormal about the neck. There was no deformity or stiffness of the spine. The chest was symmetrical and the lungs were well aerated. The heart was within normal limits. The abdomen was scaphoid and no masses were felt. The genitalia were normal for a female. There were bilaterally markedly positive Chvosteks; the patellar reflexes were exaggerated equally; the Moro embrace reaction was exaggerated.

Routine laboratory findings were as follows: Hb. 13.5 Gm.; R.B.C. 4,250,000; W.B.C. 18,450, with 50 per cent polys. Urinalysis was negative. Blood Kahn was negative. Special findings: Blood CO<sub>2</sub> content 58 per cent; calcium 14 mg.; inorganic phosphates 3.6 mg.; total serum protein 5.1 per cent; albumin 2.51 per cent; globulin 2.52 per cent; blood sugar 82; N.P.N. 21. X-ray examinations of the long bones were negative.

Admission impression: malnutrition, dehydration, tetany, mild bilateral otitis media.

She was given penicillin 10,000 units every 3 hours for 3 days only, and sulfadiazine grain 1 every 4 hours. These were discontinued because the fever subsided within 24 hours and the patient did not again have a temperature of over 100° F. rectally during the hospital stay; on several occasions it dropped as low as 95° F. Four blood transfusions were given as supportive measures.

The convulsions were fairly well controlled by repeated intravenous injections of 10 cc. of 10 per cent calcium gluconate. The vomiting did not respond to atropine, which was increased up to 15 drops of 1:1000 solution before feedings. A G.I. series was suggestive of pylorospasm.

One month after admission lumbar and cistern spinal taps were done and 2 cc. of clear spinal fluid obtained from each tap, with negative cultures.

Six weeks after admission it was observed that the circumference of the head was increasing. The right lateral ventricle was tapped and 6 cc. of brownish fluid were obtained. The culture of this was positive for paratyphoid B bacillus (*Salmonella Schottmuelleri*). A sample of the infant's blood was then taken and the serum agglutinated paratyphoid B bacilli in a dilution up to 1:320.

After the initial ventricular tap the convulsions and vomiting stopped.

One cc. of phenolsulfonphthalein was injected into the right lateral ventricle. One hour later it could not be demonstrated in the fluid from the left lateral ventricle, even with the addition of sodium hydroxide; neither could it be obtained from lumbar or cistern taps. Culture from the left lateral ventricle was positive for paratyphoid B bacillus (*Salmonella Schottmuelleri*).

Sulfadiazine, 1.5 Gm. daily, was begun at this time. Cultures were consistently positive for ten days, when a negative culture was obtained from one lateral ventricle.

Air was injected into each of the lateral ventricles and x-ray pictures showed "Considerable dilatation of the right lateral ventricle, and some irregularity of the left, with numerous reticulations throughout the air shadow suggesting fibrinous adhesions."

After three weeks cultures from the lateral ventricles again became positive for paratyphoid B bacillus (*Salmonella Schottmuelleri*).

Now 500,000 micrograms of streptomycin were given subcutaneously in doses of 50,000 every 3 hours. The sulfadiazine was continued until a total of 100 grams were given. The cultures became negative ten days after the streptomycin was begun and remained so throughout the hospitalization period.

Later phenolsulfonphthalein was injected into one lateral ventricle and was recovered from the other, but not from cistern or lumbar taps. The infant was beginning to have a hydrocephalic appearance and this became more evident with the passing of time.

The course was uneventful for the rest of the hospital stay. The infant began to thrive and on dismissal, after twenty weeks in the hospital, her weight was 7 pounds and 10 ounces. The head measured 16¼ inches in circumference. Physical condition was fairly good with the exception of the evident hydrocephalus and moderate malnutrition. The infant died three days after discharge from the hospital. The cause of death was not determined as autopsy was denied by the parents.

### Summary and Conclusion

This case represents an infant having convulsions and vomiting which were diagnosed variously as: tetany, alkalosis and pylorospasm. The true diagnosis of meningitis, which proved to be paratyphoid B (*Salmonella Schottmuelleri*), was not made through the regular spinal tap procedures, but was made after lateral ventricular tap was done.

The infection probably occurred at birth, from the mother who is a proven paratyphoid B (*Salmonella Schottmuelleri*) carrier.

We do not feel that the infection responded to sulfadiazine therapy, as the negative cultures became positive while the infant was receiving 1.5 grams per day, or 2 grains per pound of body weight per day. No conclusions can be drawn as to the effectiveness of streptomycin on this organism as it was given late in the course of the disease and insufficient amounts were available at the time.

The direct cause of death was not determined but it is doubtful that it was due to the hydrocephalus which had resulted from the meningitis.

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### DISCUSSION OF PAPER OF DR. LEONARD R. MASSENGALE

DR. HALL FARMER (Macon): I have certainly enjoyed Dr. Massengale's presentation of this rare case. I am sure I have never seen *Salmonella Schottmuelleri* infection of the central nervous system, or if I did, I certainly did not recognize it. I call to mind the words of Dr. Owen Wilson, of Vanderbilt, who said, "Gentlemen, I wouldn't know a vitamin if I met it in the road, but I'd tip my hat to it." That is the way I feel about *Salmonella Schottmuelleri*.

I do think the possibility of the organism cultured from spinal fluid on fertile eggs should be considered



seriously. This method has been used quite frequently with virus diseases in growing various cultures and I heard a discussion at the St. Louis Children's Hospital some year and a half ago where it was pointed out very definitely that they had been successful in growing bacteria from blood, spinal fluid and other body fluids on fertile egg cultures when they had failed to grow by the use of the conventional culture media. Possibly Dr. Massengale could have gotten growth from the spinal fluid by the use of the fertile egg culture.

I have certainly enjoyed the paper and I am sure I can add nothing to this excellent presentation.

DR. THOMAS ROSS (Macon): This is such a rare disease that I think mention of other things would be of interest. I was stationed in China a few months during the war and observed dysentery, obscure fevers, etc. In Shanghai, where we had no control of food, we began to get severe cases of dysentery which we were unable to run down under ordinary methods, and until we got positive cultures for *Shottmuelleri* we could not determine the cause. While I was there I made the acquaintance of a Chinese doctor who had been practicing some time and I saw with him a man 63 years old who had been ill for about four months with symptoms suggesting meningitis of some type. We were able to get a positive culture from spinal fluid as well as blood culture. This patient died after having been ill five and one-half months. Autopsy showed very thick pus lining his spinal canal, so much so that we were amazed that he could have normal dynamics of his spinal fluid. We looked up the literature and found only 38 cases, most of the cases being in German, Dutch and French journals.

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## THE SURGICAL MANAGEMENT OF THE OBSTRUCTIVE PROSTATE

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*Atlanta*

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Obstructive lesions of the prostate present many interesting pathologic variations. It is therefore obvious that no single method of treatment can be expected to correct widely varying types of lesions, and in all cases alike restore the urinary tract to normal function. The disabling effects of the obstruction on the upper urinary tract and on the circulatory system, together with the many complications that may attend advancing years, likewise require variations in the treatment administered.

Many types and methods of treatment have been proposed and used through the years for prostatic obstruction. Some very crude and irrational methods were used. In 1893 ligation of the internal iliac arteries

was performed for this condition. The folly of this procedure was soon realized. Injection of the testicle with sclerosing material was promptly discarded as useless. Partial resection of the spermatic cord left the patient with gangrene of the testicle and no relief for his urinary obstruction.

In the 18th century suprapubic prostatectomy was performed in a fashion with very poor results, because only the middle lobe was removed, leaving the lateral lobes and the obstruction. Later the snare and punch method was used by the suprapubic and perineal routes, but here again the results were poor because inadequate tissue was removed and the obstruction was not relieved. Morbidity and mortality decreased when the entire gland was removed, either suprapubically or through the perineum as practiced by Young, Freyer and others, when all obstruction had been removed and drainage was unimpeded and well established. Attention to the general care of the patient also has aided in lowering the mortality rate of prostatic surgery.

Young perfected and popularized perineal prostatectomy. This operation with certain modifications is used extensively in many of the leading clinics in this country today. In 1911 Squier described the intra-urethral suprapubic enucleation which is a worthy procedure. In recent years the electrosurgical removal of the prostate transurethrally has added immeasurably to the armamentarium of the urologist. To say that any one of these procedures should be used routinely in all obstructive prostates is as farfetched as to say no operation should be done at all. The question, however, is argued pro and con in the different clinics, as to the merits and demerits of each. It is extremely difficult to remove a small fibrotic prostate through the suprapubic route. The transurethral procedure is much simpler and furnishes better results for the patient.

Many present-day authors contend, and

rightly so I think, that the urologist should have a good knowledge of the various methods of removing the prostate, to attain the best results in the varied lesions that occur. The transurethral resection demands skilled technic and a sound knowledge of the cystourethral anatomy. It cannot be denied that many clinics excel in this particular operation, because it is used more extensively than other methods. The failure and many recurrences noted in many of the transurethral operations can be attributed oftentimes to lack of skill and in scarifying the prostate rather than adequate removal of the prostatic tissue. The perineal prostatectomy requires a high degree of technical skill and a sound knowledge of the perineal structures to avoid poor results in this procedure. The suprapubic removal requires less technical skill than the other methods mentioned, but good judgement is imperative when a two-stage operation is done on the patient that is a poor surgical risk.

When a prostatectomy is indicated, what is the method of choice? This question can only be answered when all urinary factors have been evaluated, such as a determination of the cardiac status, the degree of renal damage and the presence and degree of infection. A cystoscopy seems justifiable in most cases. A cystogram will very often give much valuable information, especially in the presence of a large vesical diverticulum. A plain x-ray film of the kidney, ureter and bladder areas is a helpful aid and should be a routine procedure, even if cystoscopy is done. The latter two procedures will rule out the presence of vesical calculus. The rectal examination, of course, will assist in determining whether or not the lesion is benign. We have no quick easy way of making a diagnosis of the very early malignant prostate.

In a large adenomatous gland with urethral distortion and vesical intrusion, in the presence of cardiac and renal damage, a

two-stage operation seems the method of choice. The primary cystostomy should be done as soon as the preliminary work up is completed. How much time should elapse before the second operation? When the infection has been neutralized, the blood chemistry stabilized and the circulatory system seems sufficiently improved, a second operation seems safe. Penicillin and the sulfonamides have materially reduced morbidity and mortality. In the presence of bladder diverticuli a two-stage operation is obviously the one of choice. If the condition of the patient permits the diverticulum can be removed at the initial operation, followed by a later prostatectomy. If bladder calculi complicate the picture, a two-stage operation is again indicated.

A clean enucleation can be had by using the Squier technic, with very little blood loss usually. Every effort should be made to combat surgical shock and shock as a result of blood loss. The prostatic fossa usually contracts after the enucleation and little bleeding occurs. Many operators use no hemostatic devices at all. A piece of gauze saturated with thrombin held in the fossa for a few minutes immediately after enucleation is of definite benefit in combating hemorrhage. Many hemostatic contrivances have been devised. The Pilcher and Foley bag catheters are two good ones. A long piece of rubber rib dam furnishes a good hemostatic agent. It is packed snugly into the fossa and can be removed with little discomfort to the patient. It does not enmesh blood cloths which is a disagreeable feature of a gauze packing. The packing is usually removed at the end of 48 hours. Serious complications crop up if the operator gets impatient and tries to hasten suprapubic closure by inserting an indwelling catheter too early. Extra infection is added to the fossa and phlebitis of the pelvic veins will ensue. Failure of suprapubic closure usually means a contracted vesical orifice or



a tab of prostate tissue which was not removed. This can be removed with the resectoscope. Prostatic tissue does recur after suprapubic enucleation, but less frequently than in transurethral resection.

The indications for perineal prostatectomy are much the same as the suprapubic route. A two-stage operation can be done if this method is selected, where the patient's condition does not warrant a one-stage operation. It is advisable that a radical perineal prostatectomy be done for early malignancy if no metastases have occurred. Many of the leading urologists prefer the perineal route in benign cases rather than the suprapubic route. If the operator has mastered the technic in the perineal approach, the morbidity and mortality are quite low. Hemorrhage is better controlled because the prostate is enucleated under vision and the bleeding points can be clamped and ligated. Surgical shock is much less marked in the perineal route. Puncture of the rectal wall will very seriously complicate the success of the perineal prostatectomy. Urinary incontinence following perineal prostatectomy has dampened the enthusiasm of many urologists who would select this method of removing the prostate. Dr. Young thought the incontinence resulted from injury to the prostatic fascia that reaches the prostate from a lateral direction. If the dissection was carried out posterior to the anterior fold of this fascia, incontinence could be avoided.

The electrosurgical prostatic operation dates back many years. The earliest instrument was devised in the late eighteen hundreds. In the last fifteen years the instrument has reached its high state of perfection. Davis, Stern and McCarthy have played an important role in developing the present instrument.

There are many advantages of the transurethral prostatic operation over the open surgical operation and in selected cases it

has been a tremendous boon to the urologist. The transurethral operation is very successful, if skillfully performed in the middle lobe hypertrophy, small lateral lobe urethral intrusion, obstructive fibrotic prostates, median bars and malignant prostates.

Great care should be used in passing the instrument into the urethra lest the penile urethra be ruptured or the rupture may occur in the prostatic portion of the urethra. The bladder wall can be ruptured or perforated at the vesicoprostatic junction by oversized bites with the loop. Either of these complications will result in urinary extravasation, and adequate drainage should be made as soon as the condition is suspected. Hemorrhage and infection may be a serious complication as in all prostatic surgery. Immediate hemorrhage should be controlled by coagulation at the time of the operation. Too much coagulation will result in sloughing and delayed hemorrhage.

The pre-operative and postoperative care are essentially the same in all types of prostatic surgery. Fluids should be copious. Renal and cardiac complications are treated the same in all three methods.

The type of anesthesia will have much to do with the successful prostatic operation. The aged patient will not tolerate the intravenous sodium pentothal very well. Gas, oxygen and ether all will give good results in the open operation if there are no pulmonary contraindications. The intraspinal injection of novocain or monocain supplemented with pontocaine is well tolerated by most patients. This type of anesthesia can be used in any one of the methods.

Transurethral prostatic resection has been a God-send to the patient with a malignant obstructive prostate with metastases. In conjunction with bilateral orchidectomy and stilbestrol therapy, he is relieved very markedly of his distressing symptoms. This procedure is only palliative. We should always be on the alert for prostatic cancer

in the very early stages when effective cure can be obtained.

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#### DISCUSSION OF PAPER OF DR. GLENN J. BRIDGES

DR. J. ROBERT RINKER (Augusta): This has been such a very excellent paper and I so thoroughly agree with what Dr. Bridges has said that I certainly didn't want to pass without emphasis on a few points.

When he started out in the first paragraph indicating that he thought it was foolish to try to adopt one method of prostatic surgery to all types of conditions present, I knew that he was off on the right foot. We have all three methods and they all have their merits, depending on what condition is present.

I like, first of all, as he said, to use transurethral resection on the cases where the middle lobe is enlarged or where the lateral lobes are not too much enlarged, but I think it is foolish to try to resect a great big prostate. The chances are that you will have to have the patient come back and resect it again and you will ordinarily do much better to enucleate it in the beginning.

About the packing after suprapubic enucleation of the prostate, I think the trend is away from packing. It is possible in many cases to ligate the bleeding points, when using the suprapubic route, with a stitch ligature, and recently I have not used packing. A good many other men are not using packing.

The perineal prostatectomy is the procedure which we use most of the time when we do open surgery (about 20 per cent of our cases) and that is particularly adaptable to the low lying prostate. If the cystogram or cystoscopic examination shows that the prostate is an intravesical type; that is, located high up in the bladder, that is not a good case for perineal prostatectomy, and it is better to do a suprapubic enucleation or resection if it is not too large.

I think Dr. Bridges has mentioned some very excellent points and given you the feeling of most urologists about this problem to date.

DR. J. M. BARNETT (Albany): Urologists are all professional golf players and I am a little disappointed at the Georgia urologists not being here to take part in the discussion of Dr. Bridges' most valuable paper.

There are just a few points that I should like to make mention of, though I am not an urologist. One is that I think due credit should be given to Dr. Hugh Young for the best there is in urology. He is first: Bentley Squier and Joe McCarthy second and third. As evidence of his contribution to the medical history of the world, there is not an educational institution in the United States, Europe, Canada or South America but what had a Hugh Young trainee in charge of its urologic department. To be accurate, 78 men of Hugh Young's teaching are now out instructing young surgeons in urology.

In the approach to the prostate—there are only three—suprapubic, perineal, transurethral—I think one of the greatest contributions to surgery in modern day practice has been transurethral surgery. There are many procedures for control of hemorrhage. Dr. Bridges mentioned the most important one, coagulation. I don't believe in packing. I don't think any of the others should be used by one with limited experience. Coagulation is the method of procedure.

Now, when you do the suprapubic you can do a little of most anything and then you won't have much control, bag or packing, but where the work is done suprapubically, I think suturing or coagulation are the methods of choice.

I am going to repeat to this Association and to the urologists that they should ever keep in mind that Hugh Young deserves credit for all of our better methods in urologic work and I think he was one of the greatest men in our time, and it is a great pleasure to express my thanks for this opportunity to discuss Dr. Bridges' paper. I am sorry the urologists left for the athletic field.

DR. GLENN J. BRIDGES (Atlanta): I appreciate Dr. Rinker's comments on perineal prostatectomy. I would like to add just one point. He mentioned that the prostate should be low and intravesical for the perineal incision. I should also like to say that the ischial spines should be well separated. I have tried to remove several where the ischial spines were close together and it is a big job to expose the prostate to do a perineal prostatectomy if that condition exists.

I had the pleasure of hearing Dr. Young about six months before he died and he made the statement in the New York Academy of Medicine that he didn't know why God Almighty put the prostate where He did. I decided that He put it there so urologists could get enough money to join the golf club.

## ADVANCEMENT IN THE TREATMENT OF COMMON INFECTIONS IN THE LUNGS

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Illness from respiratory diseases is responsible for a very large proportion of the present-day medical practice. It has been said that there is an average of two and one half colds every year for every man, woman, and child in the U.S.A.

The common respiratory diseases are: (1) common colds and sinusitis; (2) sore throats and tonsillitis; (3) influenza; (4) bronchitis and bronchiectasis; (5) pneumonia, bacterial and virus; (6) pulmonary tuberculosis, and (7) fungus infections of the lungs.

The causes of these diseases are.

#### (1) Bacterial

- (a) Friedlander's bacillus
- (b) Streptococcus hemolyticus
- (c) Streptococcus viridans
- (d) Staphylococcus
- (e) Pneumococcus
- (f) Tubercle bacillus
- (g) Proteus
- (h) Pyocyanus
- (i) Diphtheroids
- (j) Neisseria
- (k) Sarcina

#### (2) Virus A and B (the cause of influenza)



- (3) Fungus
  - (a) Coccidioides
  - (b) Monilia
  - (c) Blastomyces
  - (d) Aspergillus
  - (e) Actinomyces
- (4) Spirochaeta—especially Vincent's along with bacillus fusiformis.

Rest is nature's great aid to healing. The reason so many patients recovered with such apparent ease in the military service was because they were forced to stay in bed and were treated with "intelligent neglect". Not only is the need of rest paramount in minor infections, but it is absolutely essential in acute infections. In a survey many years ago I found that pneumonia patients in a large charity hospital were receiving twenty-six doses of medication per day.

The primary reason, however, for mentioning rest in this paper is to disagree with the new idea that is spreading through the medical profession that rest is not needed in certain respiratory infections. There are those who advocate continued activity for certain types of early active pulmonary tuberculosis. This is contrary to good medical treatment, and it is hoped that it will be discarded before too much harm is done. It is hard enough to educate the public in proper self-care and rest without having our own profession undo all the good that has been accomplished by extensive and expensive educational programs.

There is no need to fear pulmonary infection in active tuberculosis as a result of bed rest. Poorly conducted bed rest may be the cause of some maladjustment, but proper recreational diversion and correlation of collapse therapy with bed rest will aid in rectifying this condition. Good bed rest is composed of mental repose, muscular relaxation, adequate pulmonary drainage, and individualization of treatment.

Nursing care should be considered not only the care given an acutely ill patient by an attendant, but also the care the patient takes of himself when he has a mild respiratory infection. In the latter case the applica-

tion of "good common horse sense" is good medicine. In the former, nothing new worthy of mention has occurred except the advances in parenteral feeding. The literature is full of articles on the maintenance of a positive nitrogen balance by the use of plasma, whole blood, and amino-acids intravenously. Cannon<sup>1</sup> states, "The earlier hopes of some nutritionists that specific food constituents might be discovered which could enhance natural resistance have not been realized. Moreover, the probability that some type of vitamin may be found which can elevate resistance has not been strengthened by facts at hand. On the other hand, there is abundant evidence that the absence of good nutrition may induct a decreased resistance to bacterial infection." One of the effects of starvation is hypoproteinemia. I used plasma in the treatment of 209 cases of various types of pneumonia with remarkable improvement. High temperatures often returned to normal on the following day. Two units of plasma and sometimes 500 cc. of whole blood were given each day for forty-eight to seventy-two hours. There are numerous preparations of amino-acids on the market; but to be efficient, they should contain at least the seven essential amino-acids. They make a good substitute for plasma and increase resistance to infections and increase the efficiency of the sulfonamides and penicillin.

#### *Sulfonamides*

Those who have pioneered the work in the sulfonamides, penicillin, and streptomycin deserve a very great commendation. I can recall hearing an elderly physician speak before a medical society stating that in his wide experience in the treatment of pneumonia he was convinced that fresh manure poultices were responsible for his unusual success in treating that disease. The treatment of respiratory diseases has made great advancement since the poultice age.

Sulfonamides are used widely and are no longer considered new, but there are still some of us who need to be told again that the best results are obtained when blood levels are maintained between 8 to 12 mg. per 100 cc. of blood. Sulfamerizine and sulfadiazine appear to be the best of this group for treatment of respiratory diseases.

Mass prophylaxis in respiratory diseases has been tried by the U. S. Navy, as described by Coburn. In this study 600,000 naval personnel were given sulfadiazine and 300,000 similar personnel were used as controls. Hospital admissions were reduced from rates varying between 5 and 18 per thousand monthly to less than 1 per thousand monthly. Morbidity rates, however, for respiratory diseases caused by filterable viruses were unaffected. The most effective dose was 1 Gm. daily. Severe reactions occurred in 0.01 per cent of those taking this dose.

### *Penicillin*

More ways have been found to give penicillin than there are ways to skin the proverbial cat. It is given:

1. Intramuscularly in beeswax, oil, solutions and suspensions.
2. Subcutaneously in solutions.
3. Intrathecally.
4. Topically in solutions, ointments and lotions.
5. Orally in solutions, tablets, and emulsions.
6. By inhalations.
7. By bronchial lavage.
8. By bronchial instillations in solutions of peanut oil and iodized oil. Each has its own particular beneficial application.

Penicillin is not helpful in common colds, influenza, or atypical pneumonia *per se*. If these conditions become acute, however, secondary invaders are almost certain to appear for which it is beneficial. Contrary to the opinion of some writers, I give either sulfadiazine or penicillin in all acute respiratory diseases for the first three days.

The initial dose of penicillin should be 40,000 units given intramuscularly, followed every three hours by 10,000 to 20,000 units day and night. If slower absorption and excretion are desired, 100,000 to

300,000 units in peanut oil or beeswax may be given once every twenty-four hours. Certain unpleasant reactions may occur with this method of injection and it should be reserved for those cases where it is impracticable to give more frequent injections of a more rapidly absorbed penicillin.

The oral administration of penicillin has been received skeptically, and rightfully so, because of the cost (about eight dollars for twelve tablets); and because five times as much by mouth is required as when given intramuscularly. A large percentage is destroyed by gastric acidity. Chow and McKee<sup>2</sup> combined crystallin penicillin with human plasma proteins to make a large penicillin protein complex. Gyorgy and his associates<sup>3</sup> have given penicillin orally with trisodium citrate as a buffer salt to eliminate the destructive action on the penicillin by hydrochloric acid in the stomach. Little and Lamb<sup>4</sup> have used the stabilizing effects of protein and the buffer action of sodium bicarbonate in administering penicillin by mouth.

Early tests on volunteers and patients showed that when 20,000 units of penicillin were given orally, the proportion excreted in the urine was 75 to 80 per cent, which is comparable to the intramuscular administration of 15,000 units; but on the average excretion continued for four to six hours after a single oral dose, as against four to five hours after intramuscular injection. Work indicated that oral administration caused a slow rise to a peak concentration in the serum which was prolonged for at least three hours. Using the intramuscular method there was an abrupt rise of penicillin concentration in the serum to a high level fifteen to thirty minutes after injection, followed by a rapid fall. Paul and his associates<sup>5</sup> state that recently dihydroxyl aminoacetate has been investigated at the University of Iowa Hospital. The aminoacetate causes rapid buffering action while



the aluminum gives a prolonged effect.

McDormott et al<sup>6</sup> reported that the height and duration of the blood penicillin concentrations observed in fasting subjects after oral administration are of the same order of magnitude regardless of whether the penicillin was administered following anti-acid, as a suspension in oil mixed with beeswax or in plain water. With any of these methods he found that approximately five times as much penicillin is required to achieve a given blood level concentration when the material is administered by the oral as by the intramuscular route. From the studies of the urinary excretion there was no evidence that any of the following vehicles—(1) oil suspension mixed with beeswax, (2) oil suspension mixed with a shellac, (3) tricetrate tablets, (4) lecithin, (5) mucin, (6) amphogel, and (7) sterates—promoted the absorption of more penicillin than occurred following the ingestion of the material in water.

In a later paper McDormott et al<sup>7</sup> stated that in no instance was it possible to demonstrate that any method was superior to the oral administration of powdered penicillin in a capsule or dissolved in water. In his work he used both calcium and the sodium salts of penicillin. The former was given as a suspension in corn or cotton seed oil enclosed for convenience in a quick dissolving gelatin capsule. In a few instances, the oil suspension of calcium penicillin was mixed with 5 per cent beeswax before it was capsuled.

A number of patients have a moderate degree of abdominal distention which does not serve to affect the therapeutic efficiency of the orally administered material. The absorption of penicillin can be hindered, however, by inhibition of gastric mobility. Therefore, if abdominal distention is accompanied by gastric dilatation—as is so frequently the case—it is probable that

much larger doses of penicillin will be required for effective oral therapy. The presence of a moderate or pronounced degree of abdominal distention should be regarded as a contraindication to the use of penicillin by mouth.

Inhalations for the treatment of conditions of the respiratory tract have been used for many years, but only steam and certain vapors contain particles small enough to be effective. These particles must be one micron or smaller.

Solutions of 1:1,000 epinephrine and neosynephrine were used as continuous inhalations by Richard, Barch, and Cromwell<sup>8</sup> in asthma, pulmonary emphysema, pneumonia, pulmonary edema and in gas poisoning. Five per cent glycerin has been added to the solutions to prevent dryness of the throat. Five per cent solutions of the sulfonamides produced improvement in bronchiopleural suppuration as shown by the French writers Castex, Copdehourant and Pedace. Promin solutions, where inhaled, prevented the development of tuberculosis in experimental guinea pigs as shown by Brach et al.<sup>9</sup> Improvement in bronchiectasis was reported by Stacy.<sup>10</sup>

Aerosol penicillin has become very popular, enjoying wide use in the treatment of many conditions in spite of the fact that it has a very narrow field of application. It is hoped that this discussion will serve to help limit its use to properly selected cases and prevent it from being used as a racket by unscrupulous builders of large practices.

It has been found that penicillin is not inactivated by the presence of paraaminobenzoic acid in purulent exudates in contrast to the sulfonamides. A number of investigations have shown the therapeutic value of penicillin in respiratory infections when administered by nebulization. Its use in this manner has been described by Barch<sup>11</sup> and Bryson.<sup>12</sup> Knott and Clark<sup>13</sup> found that peni-

cillin dispersed as an aerosol in a room was fully active for ninety minutes. Vermelye<sup>14</sup> states that the calcium salt of penicillin was found to produce a superior aerosol and is preferred by the patients, because it has less odor and is less likely to cause coughing.

The apparatus and technic for nebulization have been perfected and simplified. I feel that compressed air (so long as it is clean) is just as effective as oxygen. Each nebulizer must be tested, for the jets in the carburetors are occasionally defective. There are many types on the market, but few are efficient. The vapophedrin nebulizer is superior to any other in use at this time. The smaller hand converted types are not efficient. The cost of the apparatus, oxygen, check valves and gauges is about fifty dollars. I use a single rubber tube from the compressed air outlet in the treatment room to the carburetor, with the elimination of the Y tube. By proper adjustment of the flow of air and instructing the patient to inhale through the nose pieces and exhale through the mouth (holding the breath as long as possible before expelling it), the results are found to be effective in selective cases.

This method of administering penicillin has been used by many physicians for many diseases, because they feel the primary cause of illness is aggravated by a chronic respiratory infection. This is an unnecessary waste of penicillin and a waste of the patient's money. Vermelye<sup>14</sup> reports the following types of infection treated:

1. Acute primary invasions of the respiratory tissues with and without pneumonitis:
  - (a) Pneumococcus types.
  - (b) Hemolytic streptococcus and staphylococcus types.
  - (c) Virus types with secondary invasions of hemolytic streptococci and staphylococcus and non-hemolytic streptococcus MG group.
2. Persistent bacterial infections of the upper respiratory tract due to pneumococci (thirty-five types), hemolytic streptococci (forty types) and staphylococci, with acute pneumonic episodes without allergic manifestations.
3. Persistent bacterial infections of the upper respiratory tract which developed into bacterial allergies in the constitutionally nonallergic patient.

4. Upper respiratory bacterial infections which develop into bacterial allergies in individuals who have an allergic type of constitution in combination with other extrinsic allergies:
  - (a) Sinobronchitis
  - (b) Eczema
  - (c) Asthma
  - (d) Migraine
    - (1) With headache as the predominant symptom.
    - (2) With hemicrania and simulated trifacial neuralgia with or without biliary viscerospasm.
    - (3) Intestinal crisis without headache.
    - (4) Psychotic or psychosomatic types.
5. Chronic upper respiratory bacterial infections which lead to glomerulonephritis and hypertension.

Many of the so-called cures by this method must be discontinued, because most of those infections that are amenable to this type of treatment would recover anyway, if given more time. When bed rest is enforced, especially is this true—even without medication. This method causes a concentration on the surface of the mucous membrane and not in the blood. Its use is limited, therefore, to (1) mild infection of a non-hyperplastic type, and (2) preparation by sterilization of the respiratory tract for anticipated surgery. Parenteral administered penicillin is not very beneficial in bronchial infections of long standing or when accompanied by large amounts of mucus and pus. If parenteral and aerosol methods are combined the results are very gratifying. Comfort may be given more quickly by the aerosol method if they are: (1) infections following influenza causing a chronic dry cough, or (2) if they are the types that have a bacterial allergy.

The important points to remember about aerosol penicillin are:

1. The size of the particles must be one micron or less.
2. The procedure is best repeated once every hour (or every four hours if oftener treatments are not practical), because the bacteria are vulnerable to penicillin only during the period of dividing and, therefore, must be given during each division cycle.
3. Swollen mucosa must be shrunk prior to inhalation of penicillin. A solution of 1:1000 epinephrine hydrochloride in distilled water gives the best results.
4. Patients should be encouraged to hold their breath following inhalations. It has been shown that this greatly increases absorption of the penicillin as is evidenced by a much higher blood concentration.



5. The purpose of this type of treatment is to cause a high concentration on the surface of the mucous membrane and not in the blood.
6. This, therefore, limits its use to those conditions that primarily cause irritation to the mucosal surface.
7. Normal saline as a diluting agent is less irritating than distilled water.
8. Rare, mild allergic manifestations do occur, such as increased coughing, mild substernal discomfort and urticaria.
9. The dose varies, but is usually 150,000 units daily in 40,000 per cc. for seven days to one month.
10. Higher concentrations can be given and do produce higher blood levels.
11. This method should in no way replace the parenteral method, but may be used in combination with it.
12. Compressed air or oxygen may be used with equal efficiency if the flow is properly regulated (six to eight liters per minute).
13. Results will vary in accordance with the selectivity of the cases.
14. There is a strong psychologic element in this type of treatment, and this element should not be used by the physician to feather his own nest.

### *Streptomycin*

Streptomycin is an antibiotic isolated by Waksonan and his co-workers<sup>15</sup> from a soil actinomyces (*Streptomyces grisei*) and has been found to be useful in controlling many infections caused by gram negative organisms. The scarcity of the drug has prevented sufficient work to give adequate reports on its efficiency.

Streptomycin may be administered, (1) intramuscularly; (2) subcutaneously; (3) intravenously; (4) intrathecally; (5) by nebulization, and (6) orally. The dose used intramuscularly is 1,000,000 to 2,000,000 (S) units per day in doses of 1 or 2 cc. of distilled water or normal saline containing 125,000 units per cubic centimeter. This dose is usually given every three to four hours or, in some instances, every six hours. It may be nebulized in 25,000 to 50,000 units per cubic centimeter.

Zintel<sup>16</sup> and his coworkers found that blood levels of streptomycin following a single intravenous injection in man are better maintained than in the case of penicillin. Detectable amounts were found six hours later as compared with two and one-half to three hours in the case of penicillin even where the intramuscular route was used for the latter drug. The main route of excretion

for streptomycin is through the urinary tract. Relatively little transfer of the drug occurs between the blood and the lumen of the gastrointestinal tract in either direction. Early side reactions have not been alarming and late toxic effects have not been so far observed.

Common diseases of the lungs treated with streptomycin, so far reported, do not show any greater tendency toward rapid recovery than when treated with sulfonamides and penicillin. The Friedlander group (*Klebsiella*) and the paracolon bacillus responded to treatment as reported by Herrell and Nichols.<sup>17</sup>

In tuberculosis, Hinshaw et al<sup>18</sup> report the effect is limited but promising. The results in man are not as promising as in animals. It has long been recognized, however, that tubercle bacilli do not act the same in the experimental animals, the test tube, or in man. Chemotherapy in animals and in the test tube has often been very promising—only to be discarded in the treatment of human beings. It may be said that extrapulmonary tuberculosis appears to respond to streptomycin better than pulmonary tuberculosis. In the lung the disease is retarded while streptomycin is being administered, but becomes acute immediately on omission of the drug.

Reactions to the drug are rare. Several million units have been administered without toxic effects. In a few cases there appears to be a slight disturbance of the labyrinth, either directly or as an effect on the nerve. The loss of equilibrium seems to be transient and present in only a few cases. Treatment of respiratory diseases with this drug is still in the experimental stage.

### *Pulmonary Lavage*

Pulmonary (or bronchiopulmonary) lavage consists essentially in the introduction of 40 cc. of normal saline into the trachea through the intercricothyroid space ten minutes after a very slow injection of 10 cc. of

a 5 per cent solution of a local anesthetic. After introduction of the solution the patient's position is changed from upright to lateral, first to the right and then to the left, and to a slight Trendelenburg position. The patient is then placed with the head and chest downward, as in postural drainage, and the solution coughed up or expectorated. This type of examination is to be condemned because of the possibility of spreading an infection to a healthy area.

#### *Intrabronchial Instillations*

For many years various antiseptics or oils have been instilled intrabronchially in the treatment of chronic pulmonary suppuration. Among these are lipiodol, gomerrol, iodinemono-chlorophenol, mataphen, mer-cresin, and capryn.

Stitt<sup>19</sup> and Latraverse<sup>20</sup> suggested the direct instillation of from 2 to 20 cc. of 5 per cent sodium sulfathiazol solution into the bronchi by laryngeal syringe or catheter, the direction of the flow being regulated by posture.

Kay and Meade<sup>21</sup> have reported the use of intrabronchial penicillin in lung abscess and bronchiectasis, with gratifying results.

Romansky et al<sup>22</sup> have reported the use of penicillin in iodized oil for intrabronchial instillation. Calcium penicillin can be thoroughly blended with 40 per cent iodized oil, the resulting mixture containing 1,500 units per cubic centimeter. Stability tests show that the penicillin remains suspended even after sixty days storage at room, incubator, or refrigerator temperatures.

After preliminary cocaineization of the posterior pharynx, 7 to 10 cc. of penicillin in iodized oil are introduced into the diseased area. This method causes little discomfort. Many cases will show as much as 50 per cent reduction in the amount of sputum over a seven-day period. This will not cure where deformity is present, but is recommended for temporary relief and for

preparation of the patient for lung surgery. This method is said by some to be more beneficial in chronic bronchitis and bronchiectasis than the intramuscular route. If necessary 30,000 to 50,000 units can be given each day.

#### *Vaccination*

Up to the present there is no treatment for virus infections except symptomatic and prophylactic. The influenza virus A and B have been isolated, but the virus of common colds and atypical pneumonia have not been isolated.

Salk and his colleagues<sup>23</sup> have shown that vaccination with the A and B vaccine is a very beneficial prophylactic measure.

#### *Fungus Infection in the Lungs*

Various parts of the U.S.A. have different amounts of fungus infections, therefore what is common in one locality may not be so in another. In general, the treatment of pulmonary fungus infections is highly unsatisfactory, and little advancement has been made. Hiatt and Martin<sup>24</sup> reported a case of moniliasis cured following injections of a small amount of immune rabbit serum. Dodson<sup>25</sup> reports that both sulfonamides and penicillin are effective in the treatment of actinomycosis. This is confirmed by others.<sup>26</sup> Histoplasmosis is rare (76 cases) and the treatment is still experimental. Antimony preparations and diaminidine preparations have been used. X-ray and radium therapy have been tried. External fungus infections have been treated experimentally with sodium propionate with good results, and it is hoped it can be used internally at some future time.

#### *Summary*

1. Common respiratory diseases have been listed and the causative organisms have been enumerated.

2. Rest has been advocated in place of activity in early active pulmonary tuberculosis. Rest has otherwise been discussed.

3. Parenteral feeding with plasma and



amino-acids has been discussed, and advocated.

4. Brief mention of the sulfonamides has been made, with a plea for sulfa blood levels to be maintained between 8 and 12 mg. per 100 cubic centimeters of blood.

5. Penicillin has been discussed with especial mention of methods, and dosage. Oral administration is considered impracticable except in selected cases. Aerosol administration has a very narrow field of efficiency. Beeswax as a vehicle used to prolong absorption and excretion has been mentioned.

6. Streptomycin has been discussed. Its effects in respiratory diseases, as reported, are not cause for enthusiasm. Streptomycin has been thought to retard the growth of the tubercle bacilli but has no curative effects on pulmonary tuberculosis. Methods of administration have been given.

7. Intrabronchial instillations have been discussed.

8. Pulmonary lavage has been condemned.

9. Virus diseases (common cold, influenza, and atypical pneumonia) have been discussed. Vaccination with influenza A B vaccine has been shown to be a beneficial prophylactic measure.

10. Fungus infections have shown poor response to treatment in general. Actinomycosis responds to penicillin therapy.

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## TUBERCULOSIS IN PRIVATE PRACTICE

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To deviate from the orthodox pattern sometimes provokes criticism, but my attempt to refresh your memory on an old subject is done with no feeling of animus to anyone. My remarks are an attempt to improve the general health conditions of our State and to make an effort to have our physicians more tuberculosis conscious.

Dr. Herman E. Hilleboe of the U.S.P.H. Service has said, "The average patient has a great deal of confidence in his private physician and expects him to treat tuberculosis much as he would accept other family emergencies. Psychologic factors make this

desirable and practical considerations make it feasible, especially if the physician possesses sufficient broad understanding of tuberculosis and modern therapeutic methods. Sanatorium care is no longer the only method of tuberculosis control. Many minimal lesions and a limited number of inactive advanced lesions are amenable to outpatient supervision under strict medical care. This supervision and care can often be rendered by the alert general practitioner who possesses modern knowledge of the diagnosis and treatment of tuberculosis."

This modern knowledge consists of a few very practical, simple, and fundamental principles. In these days of new gadgets and procedures it seems difficult for medical men to think about and apply simple measures, as the use of an adequate diet and rest, mental and physical.

It is almost child-like to call your attention to a few of the do's and don'ts in tuberculosis, but here they are:

Do inquire as to contacts and the chronic bronchitis of grandparents. Tuberculosis is a contact disease.

Do ask about undue fatigue, the earliest known symptom of the toxemia produced by tubercle bacilli.

Do weigh your patients and ascertain fat loss if any, for progressive loss of weight, unaccounted for, is important. Ten pounds loss in an adult is sufficient evidence for consideration.

Do find out about digestive disturbances such as aversion to fats and loss of appetite. Many an appendix has been removed in a tuberculous patient. Most tuberculous patients are poor or "finicky" eaters.

Do not forget that many patients notice a feverish feeling and a flushed face. Tonsils have often been sacrificed for a low grade fever that later proved to be due to tuberculosis.

Do not fail to have these patients return for further questioning at regular intervals.

Patients frequently fail to relate many details of importance at the first visit.

Do not ever tell a patient that blood spitting of a dram or more might have come from tonsils or teeth. Tuberculosis, bronchiectasis, and heart disease are still the most common causes of hemoptysis. Frank hemoptysis warrants careful study.

Do not fail to have the sputum examined in all chronic coughs. Though there are listed 137 causes for cough, tuberculosis is still the most common cause of chronic cough. Cough may be non-productive in early disease. Gastric washings may reveal a positive result in these cases. Sputum examination is one of the most sadly neglected procedures and yet one of such great diagnostic importance. The only indisputable evidence of the disease is a positive sputum or gastric washing. Do not forget that your State Board of Health makes these tests if you do not have facilities.

Do make provisions for proper x-ray examination of the chest. It gives more early information than any other single test.

Do not be afraid to ask for aid in your interpretation of x-ray studies and do remember a poor x-ray is valueless even to a good interpreter, and a good x-ray is valueless to a poor interpreter.

Do not hesitate to inform your patient of your suspicions and do not forget that many of them are ahead of you in their anticipation of your opinion. It pays to be honest.

Do not fail to use the tuberculin test, but remember that a negative result is of greatest importance because of the specificity of the test.

Do not keep children out of school with a positive skin test and a primary infection. Children rarely have a re-infection type of disease, which is the type that is a menace to others.

Do remember the difference between infection and disease.



Do not advise exposure to sunlight. It is hazardous to patients with active pulmonary lesions. I have seen frank hemoptysis after a severe sunburn. Sunlight kills the exposed bacillus, but does not kill the bacillus in the body.

Remember there is no ideal climate and the emphasis should be placed on change rather than climate. Occasionally climate may be of value in complications, such as asthma, hypertension, etc.

All patients with anal fistulas or chronic draining sinuses around rectum should have a chest x-ray. Many of these are forerunners of or accompany pulmonary tuberculosis.

Do not forget that many wet pleurisies or simple pleural effusions are tuberculous in origin. These cases should be treated for three or four months on a presumptive diagnosis. Then after absorption or withdrawal of fluid the structures can be visualized by x-ray. Never be satisfied to say that pain in chest is muscular or neuralgic, because pulmonary tuberculosis with peripheral disease is often accompanied by pain. True, there are about 70 odd causes of pain in the chest. So rule out tuberculous disease as one.

An indisputable diagnosis can be made on the presence of tubercle bacilli in the sputum.

Do not forget that (1) hemoptysis of one dram or more, (2) x-ray infiltration in parenchyma of lung, (3) pleural effusion, and (4) moist rales (posttussis) heard on more than one examination, are four of the most important signs and symptoms. A presumptive diagnosis of pulmonary tuberculosis should be made on any two of these.

Persistent fever, with afternoon rise, and increased pulse rate are frequently present. Rise of temperature in women during, just before or after menstruation should arouse suspicion. Repeated occurrences of acute

respiratory infection should not receive the usual alibi of a cold or relapse of "flu". A chest x-ray and sputum examination should be made to rule out the presence of tuberculosis.

Granted your diagnosis is just a presumptive one, what is your responsibility to your patient? At this stage you may save or lose a life by your advice. Your responsibility is to issue a warning and place the patient in the category of a possible tuberculous patient.

Rest is the most important single factor in treatment. Bed rest, yes, but also mental rest by assurance, and reassurance that opportunities for recovery are greatly enhanced by early rest. The period of time for rest is indeterminate and must depend on the individual case. Of course, you may err at times but a period of rest (with adequate diet) never does harm to any patient. Do not force feed these patients as of old. Remember a patient in bed has less caloric requirements.

While the patient is resting a temperature study, sputum examinations and sedimentation rates, and many other important clinical and laboratory studies may be made if indicated, or if not already done.

Many of these patients are anemic and often need iron, vitamins and other constructive procedures which may be administered during this observation period. Decreased temperature, retrogressive x-ray lesions, lessened cough, sense of well being, normal sedimentation rate, all are criteria that determine the prognosis.

At your visits further reassurances may be given such as discussion of various collapse procedures or their combinations as a mode of treatment. To remind the patient that such procedures as pneumothorax, pneumoperitoneum, phrenic interruption, and even total pneumonectomy are life-saving methods of treatment is your duty.

You may occasionally lose a patient by

this procedure but in the end you will gain and save many lives and long periods of suffering and, after all, is not this your real objective?

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THE SOCIAL, PROPHYLACTIC,  
MEDICAL, AND SURGICAL ASPECTS  
OF BRONCHIECTASIS

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Bronchiectasis is a large topic to cover in a short discussion of this type. However, it is a disease of such frequency and importance that it is well to consider certain phases which may be didactically described.

Bronchiectasis is a progressive, destructive disease causing an appalling aggregate morbidity, and psychologic and economic disturbances. There are some questions remaining relative to the etiology of the disease, but few if any questions in regard to prognosis. Fundamentally the disease consists of an endobronchial and peribronchial chronic, destructive and progressive inflammation. Many feel that intermittent or prolonged bronchial obstruction plays an important role in the production of this process. Others lay great stress upon the importance of chronic upper respiratory tract infection. There are still some accepted types of the disease having a congenital origin. Allergic states may mimic the disease but it is extremely questionable that allergy is much concerned in this destructive disease.

We are all familiar with the physical symptoms and findings—the chronic cough, recurrent episodes of pneumonitis, chest pain, fatigue, hemoptysis, and fever—but we tend to overlook the psychologic toll which this disease demands. This feature has been so well described by Churchill<sup>1</sup>

that it is well to quote extensively from this author: “Bronchiectasis, severe or mild, is a disease of youth and early adult life and exerts its influence on both body and mind during the formative periods—an age in which social contacts are established, personality is crystallized and foundations for life’s work are laid . . . The chronic cough inconveniences and distresses the patient and renders him sensitive to its effect upon others . . . The result in a sensitive individual is a tendency to shun social contacts . . . In quiescent intervals the smouldering infection gives rise to a sense of fatigue and is insidious and vicious in its effects . . . The lack of physical endurance paralyzes plans and ambitions for future career . . . The confusion of pulmonary tuberculosis because of the cough, sputum and hemorrhages, raises important psychological conflicts . . . Young women with bronchiectasis usually consider themselves unfit to bear children . . . When the doors both to marriage and a career of choice are closed, the future appears to hold little promise for any young person.”

When one appreciates that 70 per cent of the patients with this disease are destined to remain single, that one-fourth of the remainder will undergo early divorce or separation, the effect upon the social destiny is emphasized. The repeated need for hospitalization and medical care constitutes a further financial drain upon, and worry for the patient. Thus, in summary, what may one expect other than an abnormal psychologic outlook from a patient who is chronically and recurrently ill, whose illness acts as a constant drain upon the patient’s and his family’s finances, whose social activities are markedly limited, and for whom there is no promise of a productive future? This aspect of the disease is of importance because it stresses the demand for adequate diagnosis and therapy, and also because we must be conscious of this background and

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From the Department of Surgery, Emory University School of Medicine.

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prognosis in the handling of these patients. Such are the social and psychological features of the disease.

In this day of prophylaxis, what are the preventive measures available to us relative to this disease? It is difficult to lay down definite rules of prevention until the etiologic factors are fully understood. However, certain factors are so frequently precedent to, or associated with the disease, that they deserve mention. The occurrence of bronchiectasis, secondary to concurrent childhood diseases, or exanthemas complicated by pneumonia, means that one must suspect an etiologic factor present here. These are frequently streptococcal pneumonias and frequently lead to a state described as "unresolved pneumonia." It is my firm conviction that much of this is really atelectasis with associated infection, and that proper bronchoscopic attention, plus chemotherapy at this stage, can prevent subsequent progressive bronchiectasis. Whether the accessory nasal sinuses are coincidentally infected, or if they play an etiologic role, it is certain that untreated sinus disease contributes to the progress of the underlying bronchiectasis. Therefore, the prophylactic aspect of the disease should consist in: (1) Adequate early attention to persistent pulmonary symptoms after severe or combined childhood diseases, so-called "unresolved pneumonias"; (2) thorough attention to infection of the accessory nasal sinuses, and (3) the major factor in all prophylaxis, a consciousness of the disease, bronchiectasis, its early symptoms and predisposing factors.

Much has been written regarding the medical aspects of bronchiectasis. It is sufficient now to say that bronchiectasis is a disease characterized by spontaneous remissions, recurrences and progressive destruction. Thus many remedies have been claimed to have curative value, when indeed they have been only palliative at best and

mainly coincident with spontaneous remissions. A careful follow-up of 400 cases by Perry and King<sup>2</sup> shows the following conclusions relative to medical remedial measures: In regard to morbidity, they state, "Most of the patients continue to have the same symptoms of cough, sputum, and occasional hemoptysis. Often the amount of sputum increases and becomes foul in odor, although the patient mercifully may lose his appreciation of this fact through the loss of his sense of smell. He remains, however, unpleasant to relatives and friends, and suicide, figuring twice in the causes of death in our series, indicates the patient's own unhappiness in living with his disease."

Riggins<sup>3</sup> noted that the re-admission rate was higher for bronchiectatics than for an equal group of patients with tuberculosis at the Lennox Hill Hospital. In his series the patients were subject to frequent hemoptysis and secondary fever, head colds, sinusitis, pleurisy, and asthmatoïd attacks. The patients were generally under par and had frequent hernias; 25 per cent of the patients part-time, and 35 per cent were unable to work at all. Under a medical regimen carried out in 100 patients, 13.3 per cent were characterized as improved; 46.6 per cent listed as unchanged, and about 41 per cent became definitely worse. No cures were achieved without surgery. Roles and Todd<sup>4</sup> reported a 49 per cent mortality in a six year follow-up of 49 cases treated by non-surgical methods. In a review of 200 cases by Head<sup>5</sup> very few lived past the age of 40 if the disease had its onset during the first decade of life. In the study of 400 cases carried out by Perry and King, 26 per cent died during a twelve year period, 41 per cent of the traceable cases were found to be dead within the first four years. Therefore, one may safely conclude that medical measures are, at best, palliative. However, inasmuch as such a high percentage of cases may present themselves at a stage too late for

curative measures, it would be well to dwell for a few moments on the best accepted measures for such palliation. Let us paraphrase the statements of Alexander<sup>6</sup> in this regard: "Every bronchiectatic patient should have at least one bronchoscopic examination, not only because some otherwise important intrabronchial lesion may be discovered, but also because the aspiration of secretions and the chemical shrinkage of the bronchial mucosa often bring about improvement in the symptoms which, in many cases, is astonishingly great."

The greatest single palliative measure is, undoubtedly, postural drainage. Its aim is to maintain the least amount of retained bronchial pulmonary secretions and thus reduce toxic absorption and obtain delay in the progress of the disease by reduction of the intrapulmonary infection. Postural drainage demands the maximum inversion of the torso, so that the dependent portions of the pulmonary tree will obtain the maximum benefit from the force of gravity. This has been well described by Alexander, who states: "Postural drainage should be carried out by the patient's lying over the edge of the bed or table sufficiently high to cause his torso to be inverted perpendicularly when his hands are resting on the floor. The taking of a half-dozen deep breaths before each half-dozen hard coughs loosens the secretions better for expectoration, and aerates the affected portion of the lung better than if the inversion and coughing are alone relied upon. Cycles of deep breathing and hard coughing should be repeated until the patient feels that no more secretions can be loosened for expectoration. The duration of the postural drainage should not be prescribed in minutes . . ."

It is also of considerable benefit to increase the bronchial secretions by means of ammonium chloride, iodides, or medicated steam inhalations, or the inhalation of a nebulized spray of 1:100 dilution of epine-

phrine. This type of medication aids in the maximal evacuation of secretions. Medications for the decrease of cough are obviously harmful. Chemotherapy has proved of little use in this disease, although it still has many adherents, but it is felt that such reaction on the part of physicians has been due, in the main, to the coincidence of the normal remissions which characterize the disease. However, in occasional cases both penicillin and the sulfonamides, whether given by mouth or by nebulizer, have had an apparent excellent effect. Considerable attention should be paid to infections of the upper respiratory tract. General hygienic measures are of course indicated, with attention being directed to climate and anemia. The results from desensitization have been almost uniformly disappointing in true bronchiectasis, and one may rest assured that when good results are obtained from such therapy, that the underlying disease has, in reality, been just a true allergic bronchitis. Therefore, in summary, one may say that inasmuch as a large group of bronchiectatic patients may not be eligible for surgical methods of treatment, that the best modes of palliation would consist of bronchoscopy, proper postural drainage with the aid of expectorants, and adequate attention to upper respiratory disease and general hygienic measures.

There is now no question that surgery offers the only permanent cure for bronchiectasis. Lobectomy is now a safe procedure, but essentially it has only been so offered for the past ten years. And, because of the memory of hazards associated with lobectomy prior to that time, there is still some unnecessary hesitancy upon the part of some members of the profession to suggest resection. In 1932 a series of 40 lobectomies was reported by Lilienthal,<sup>7</sup> but these had an associated mortality of 62.5 per cent. By 1939 report of 30 lobectomies with a 9 per cent mortality was



offered by Bradshaw<sup>8</sup> and his co-workers, and Edwards<sup>9</sup> reported a 12 per cent mortality in 166 cases. By 1940 Churchill<sup>10</sup> was able to report a 3.3 per cent mortality in 70 cases. In 1946 Meade<sup>11</sup> is able to present 244 lobectomies with a single mortality. It should be mentioned, that in this considerable number, that this amazingly low mortality rate has been obtained upon essentially unilateral cases, but in my own series of 62 lobectomies there has been but one death which was due to a laboratory error in the crossmatching of blood, and out of these 62 cases 43 patients had bilateral disease. Thus, what had been a procedure of high risk now carries a very reasonable mortality rate. The procedure has, furthermore, been perfected so that postoperative empyema is now to be expected in less than 10 per cent of cases, and these empyemas have certainly not proved troublesome. The reasons for these remarkable statistics rely on several factors, the most important being: (1) satisfactory methods of diagnosis and the sending of patients for surgical treatment before the disease becomes too far-advanced; (2) improved methods of anesthesia; (3) improved methods of technic; (4) the prophylactic use of the chemotherapeutic agents such as penicillin and sulfonamides prior to surgery and during the period of convalescence; and (5) the use of the bronchoscope as an adjunct to pre- and postoperative care of these patients. The procedure has also been perfected to the extent that partial or segmental removal of diseased lobes can be carried out with preservation of normal lung tissue, and also by staged procedures areas of bilateral disease may be removed. Therefore, if a patient is suitable for surgery we can offer him a safe procedure which carries a good guarantee for cure. It should be mentioned that when the accessory nasal sinuses are also involved, they should also receive adequate surgical therapy. It is our

policy to do this two or three months following lobectomy.

### *Summary*

The problem of bronchiectasis has been approached from four major aspects; namely, the psychologic, prophylactic, medical, and surgical therapeutic considerations. The extreme importance of the social and psychological effects of the disease has been stressed, and the chronic, debilitating nature of this disease has also been emphasized. Attention has been drawn to the probable etiology and to the methods for prevention, which are concerned with the early eradication of endobronchial obstructive lesions. The relationship to inflammatory lesions of the nasal sinuses has been discussed and attention drawn to the therapy indicated in this region. A summary of the findings of several investigators upon the results of medical attempts to cure the disease has been described, and the conclusion reached that the cure of the disease relies upon eradication of the involved tissue by surgical measures, but that there are still many cases which are not capable of surgical cure because of the extent of the disease, or secondary debilitating factors, and the best methods of palliative treatment of these patients have been described. The evolution of the surgical attacks upon the disease, the present day mortality and morbidity figures associated with lobectomy, and the factors involved in this remarkable improvement in results, have been considered.

### *Conclusions*

1. Bronchiectasis is a disease which affects a large group of patients, and its effect upon the patient, both his psychic and organic structure, produces an appalling aggregate amount of disability.

2. The economic effects of the disease have been stressed.

3. Bronchiectasis, by definition, implies a permanent destructive lesion, and there-

fore demands early attention if the disease is to be prevented.

4. Attempts to cure the disease by medical measures have been essentially unsuccessful, but certain palliative means have been found to aid the comfort of patients who are not satisfactory surgical risks. These palliative measures rely, in the main, upon adequate bronchial drainage.

5. Lobectomy is now the accepted mode of attack upon the disease and, in good hands, should not entail a mortality rate greater than 2 to 4 per cent.

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### SUPERIOR SULCUS PULMONARY TUMOR (PANCOAST SYNDROME)

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Figure 1 shows a homogeneous opacity at the apex of the right lung. This type of apical opacity, when associated with intractable pain in the region of the corresponding shoulder girdle, usually indicates a malignant pulmonary tumor. We owe much of our knowledge of this syndrome and its ease of diagnosis to the late Dr. Henry K. Pancoast,<sup>1</sup> formerly Professor of Radiology at the University of Pennsylvania, and it is with justice called Pancoast's syndrome or Pancoast's tumor. Rib erosion is also frequently seen on the x-ray films. Clinically, there may be atrophy of the muscles of the corresponding arm and hand. Horner's syndrome, resulting from cervical sympathetic paralysis, is present in about 50 per cent of



Figure 1  
Malignant tumor of the Pancoast type in the apex of the right lung.

the cases. The shoulder girdle pain has at times led to confusion with periarthritides of the shoulder. Other cases have been considered pulmonary tuberculosis on the basis of x-ray findings.

The x-ray film is that of a 56 year old man, accountant by profession, first seen on June 6, 1945. He was complaining of pain in the right shoulder. This pain had begun about one year previously, and had continued with increasing severity, extending down the right side of the dorsal spine, and involving the right axillary region, the right upper chest, and the right arm. One month prior to consultation he had been obliged to give up his work on account of inability to write. The pain had been partially controlled with codeine and aspirin. He stated that during the past few weeks he had with an effortless cough brought up several tablespoonfuls of blood-streaked sputum daily. He had lost 20 pounds in weight since onset.

Physical examination showed barely perceptible fullness above the right clavicle, and indefinite dullness on percussion above and below the clavicle. There were no rales, and no detectable changes in the breath sounds. The right pupil was about twice the diameter of the left. There was no exophthalmos, and no drooping of the right eye lid. The sputum was negative for tubercle bacilli.

A diagnosis of malignant tumor of the Pancoast type was made, and the patient consulted the Ochsner Clinic, New Orleans, for an opinion in regard to possible surgical treatment. I am indebted to Dr. Alton B. Ochsner for an account of his subsequent course. Dr. Ochsner decided to give the patient the benefit of surgical exploration, but immediately saw that removal of the tumor was impossible, and the wound was closed. A biopsy specimen was taken and showed that the tumor was a bronchiogenic carcinoma of the squamous cell type. Death occurred 14 days after the operation.

Stein<sup>2</sup> has recently reported 15 cases of this syndrome, in 12 of which there were either biopsies or autopsies. Eleven of these 12 cases were bronchiogenic carcinoma and



I was a metastatic sarcoma from the femur. The great majority of the cases have also been found by other observers to be bronchiogenic carcinoma. It is generally believed that the symptoms and course are due to location and invasiveness of the tumor rather than to any particular cell type.

Death has occurred in all cases recognized up to the present time. In no instance has it been possible to remove the tumor surgically, and irradiation has not been even of palliative benefit. However, with increasing knowledge of the syndrome earlier recognition may render surgical cure in some cases possible.

I wish to mention two other features of this syndrome; namely, rib erosion and Horner's syndrome. My case showed rib erosion on an x-ray film made with deeper penetration than the film in Figure 1. He did not show Horner's syndrome when seen by me. However, I am informed by Dr. Ochsenrath that Horner's syndrome was present when he was examined in New Orleans about ten days later.

Since Horner's syndrome is present in about 50 per cent of these cases, its existence is important because its presence can be determined by simple clinical inspection. Horner's syndrome is due to paralysis of the cervical sympathetic nerves. These nerves supply sympathetic fibers to the eye. Their paralysis through invasion from a malignant tumor at the pulmonary apex results in contraction of the pupil, exophthalmos, and drooping of the upper eye lid. This drooping of the lid is referred to as pseudoptosis; there is no loss of voluntary raising of the upper eye lid as occurs in paralysis of the third cranial nerve. The resting eye lid droops as a result of paralysis of smooth muscle fibers in the levator palpebrae that are supplied by nerve fibers from the cervical sympathetic.

### Summary

A superior sulcus pulmonary tumor (Pancoast syndrome) is characterized by intractable shoulder girdle pain, by an x-ray opacity at the pulmonary apex, and frequently by Horner's syndrome and rib erosion. Of these, the most important features are the pain and the x-ray opacity. A typical case of this syndrome has been presented. The ease of diagnosis renders it important for physicians to be acquainted with this syndrome. The outlook up to the present has been hopeless, though it is hoped that earlier diagnosis in the future may make surgical cure possible in some cases.

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## SOME NONSPECIFIC FACTORS INDUCING ASTHMA, AND THEIR TREATMENT

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*Atlanta*

Early in the study of asthma it was recognized that this disease, in children, often dates from an attack of whooping cough, measles, influenza, bronchitis, or acute coryza. William Salter, writing in 1868, mentioned this as a well established fact. Previous to the attack of the infectious disease no wheezing is discernible; but after complete recovery from the infection asthmatic attacks continue at varying intervals and for an indefinite period, often precipitated by a "cold," a condition known as "asthmatic bronchitis." Between attacks the lungs are often perfectly clear.

All of you who are in general practice will have seen cases of this type and must have wondered whether they were primarily due to bacterial allergy, to atopic sensi-

tivity to inhalants or, perhaps, foods, or to some other combination of factors. Recently there has been a considerable amount of work on the pathologic physiology of the respiratory tract, which throws some light on this question.

It is clear that in these cases the asthma is not due to whooping cough, measles, or influenza, because the attacks of wheezing continue long after these diseases have been cured and forgotten. The relationship to colds is more intimate, but a careful history will usually show that some attacks are precipitated by colds, whereas others are not. Moreover it is usual to find, in such cases, skin tests to inhalants and other evidences of atopic disease, such as a positive family history of allergy, and associated allergies. Thus these cases must involve something more than bacterial allergy.

Diseases such as whooping cough, measles, influenza, bronchitis and acute coryza can cause local damage in the upper respiratory tract. The simplest hypothesis which would account for the facts would seem to be that these children have a sub-clinical atopic allergy which becomes of clinical importance due to some damage caused by these infections.

Thus the nature of such damage becomes of considerable interest. One of the factors that must be considered is the actual size of the bronchi and bronchioles. X-ray studies have shown that much of the dilatation which the lung undergoes in inspiration is due to expansion of the bronchi and bronchioles.<sup>1</sup> Any factor such as infection, with edema and inflammatory irritation, which prevents normal dilatation of the bronchial tubes on inspiration, should tend to precipitate asthma.

More important may well be the action of the cilia of the respiratory tract in removing mucus. The nose, trachea, and bronchial tubes down to the junction of the respiratory

and terminal bronchioles are covered with an epithelium which is characterized by ciliated surface cells interspersed with fairly numerous goblet cells (Figure 1). Action

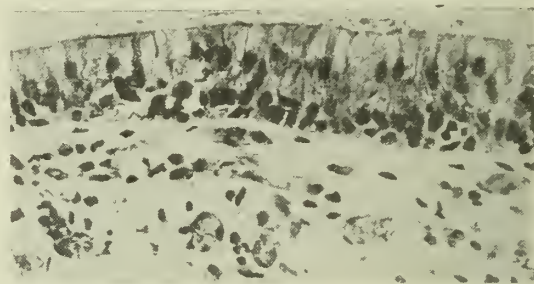


Figure 1  
Section of the epithelium lining of a human bronchus 3 millimeters in diameter (x500).

of the cilia has been extensively studied in recent years. According to Hilding<sup>2</sup> the cilia move at the rate of 250 cycles a minute. Small groups move in unison. The cilia are capable of moving huge loads, and their efficiency increases with pressure up to the optimum pressure of about 12 grams per centimeter. For the best results it is important to have mucin of the proper viscosity. Hilding observed that in the posterior two-thirds of the nose, which is ciliated, the direction of the flow is backwards and downwards and the rate of movement of India ink particles placed on the mucous membrane is 3 to 6 millimeters a minute. The mucinous film is replaced every ten to fifteen minutes. Furthermore, the evidence indicates that these cilia are very important in raising mucus from the lungs.

Hilding also observed that in acute coryza there is a great destruction of cilia and loss of cells from the mucosa. Such damage from the trachea in influenza is shown in Figure 2, with extensive injury to the cilia, and even desquamation of epithelium.

Two other observations made by Hilding<sup>3</sup> would seem to be of great interest. In experiments on rabbits he found that increased breathing through the respiratory tract caused an increase in squamous-like epithelium with extensive loss of cilia. On the





Figure 2

Trachea in influenza (x300) showing desquamation of epithelium, congestion of mucosa and infiltration with inflammatory cells.

other hand, he found that complete closure of a respiratory passage caused a great increase of goblet cells with increased secretion and extensive loss of cilia. This would seem to have a direct bearing on asthma, as Hilding,<sup>1</sup> Jorgensen,<sup>5</sup> Fraenkel,<sup>6</sup> and Huber and Koessler<sup>7</sup> have all reported a great increase in the goblet cells of the bronchial mucous membrane in fatal cases of asthma.

These two effects are clearly shown in the following illustrations from Hilding's paper<sup>3</sup> (Figure 3). In "A" one sees the high columnar epithelium from the middle

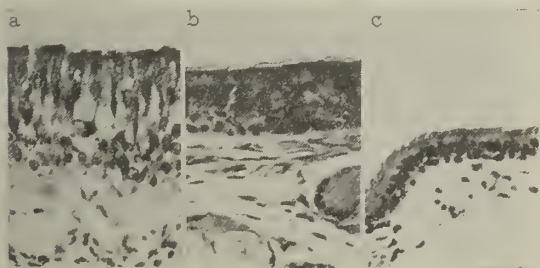


Figure 3

Typical sections of the normal mucosa membranes from (a) inferior turbinate, (b) middle meatus and (c) frontal sinus of the dog (Hilding).

third of the inferior turbinate of the rabbit, and "B" shows epithelium from the middle meatus. "C" shows the mucous membrane from the frontal sinus of a dog. All of these mucous membranes are liberally furnished with cilia, and show but few goblet cells. In Figure 4 one sees the effect of closure of one nostril upon this epithelium. In "A" is shown changes in the epithelium from the open nostril, under the influence of in-

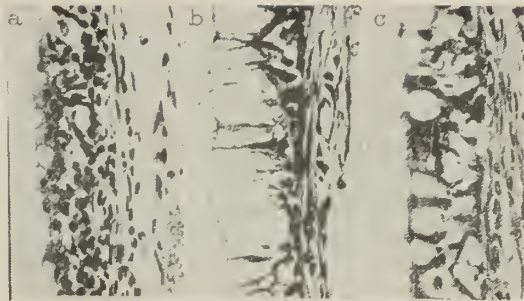


Figure 4

Nasal mucous membrane after surgical closure of one nostril (Hilding): (a) open side; (b) closed side opposite a; (c) closed side posterior to b.

creased passage of air. It is irregularly stratified and shows only a single intact cilia and several short fragments of others. In "B" is shown epithelium from the closed side opposite the site of "A", which is suffering from a diminution of air flow. The contrast with the side in which air is increased is extreme, as here every cell has become a goblet cell filled with mucin and without cilia. In "C" is shown epithelium from the closed side posterior to the section shown in "B". Here, as would be expected, the change is not as great; only half the cells have become goblet cells.

It is important to remember that sections of the lung following death from asthma often show many or all of the bronchial tubes plugged with thick, viscid, mucin, which is adherent to the wall of the bronchus. Microscopic examination reveals a great increase in goblet cells, with the mucus of the bronchial plug connecting with the mucus of the goblet cells themselves. It would therefore seem reasonable to conclude that ciliary damage accompanied by an increase in goblet cells plays an important role in asthma by producing an excess of secretion which is difficult to raise.

With these facts at hand we are in a position partially to reconstruct what goes on in a case of asthmatic bronchitis. One can easily understand how, in a patient suffering from subclinical hypersensitivity to inhalants or other allergens, damage to the

respiratory mucous membrane by an acute upper respiratory infection will destroy the cilia, and increase the secretions, partly by increasing the goblet cells, and probably at the same time cause some narrowing of the lumen of the bronchial tubes by mucous membrane edema and muscular constrictions. In such predisposed patients these changes are sufficient to cause wheezing. As would be expected, when the infection is over the patient usually makes a good recovery from his asthma.

It is quite possible that the cilia of the respiratory tract are influenced by nervous reflexes, as Seo<sup>8</sup> found a closely integrated reflex between the dorsal surface of the tongue and the palatal cilia. Morphine was found by Hacht<sup>9</sup> to slow the action of the cilia, whereas caffein increased their activity greatly. The latter finding has been confirmed by Worley.<sup>10</sup>

Logical emergency treatment would include measures to modify the viscosity of the mucus, as with potassium iodide; measures designed to reduce respiratory infection; the use of agents dilating the bronchi; and avoidance of narcotics. Over the longer term allergic studies designed to remove or desensitize to the offending substances, and improved resistance to infections, are most important. A careful study of the history will usually indicate the relative importance of allergy and infection in any given case.

While pure bacterial allergy unquestionably exists, from findings such as the above one suspects that usually upper respiratory infections precipitate asthma indirectly by damaging the respiratory mucous membrane of individuals hypersensitive to dusts.

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## MAGNETIC REMOVAL OF FOREIGN BODIES FROM THE FOOD AND AIR PASSAGES

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A few years ago the General Electric Company introduced a new magnet. This magnet is an alloy of aluminum, nickel, cobalt and iron, fused under very high pressure at almost the melting point, in reducing gas. Of the several such alloys, the most powerful synthesized is "cast Alnico-V", which can lift 25 times its own weight. Because the alloy is brittle, it is most useful if the fusion is done in a mold of the desired size and shape. Should the magnet ever lose its virtue, it can be remagnetized.

Although magnets were used more than a century ago in attempts to remove metallic objects from the human body, success was not often achieved until recent years. Electromagnets have proved successful in removing metallic splinters and other fragments from the eye, but in general magnets have been clumsy, cumbersome and expensive. The Alnico magnet, however, can be made small enough to be passed through even a 4 mm. bronchoscope. Although the Alnico magnet was offered for use in ophthalmology in 1943, its first reported use in the removal of foreign bodies from the food and air passages was a year later.

My first model of the magnet, a cylinder 3.5 cm. long and 0.5 cm. in diameter, for special use in endoscopy was presented before the Southern Medical Association in November 1944. This model is now used only for foreign bodies in the esophagus and stomach. For such purposes it is fixed to a Levin tube, size 12F. A metallic stylette

From the Ponce de Leon Ear, Nose and Throat Infirmary.  
Read before the Medical Association of Georgia, Macon,  
May 8, 1946.



in the tube increases the control of its motility. A small opening in the tube at the magnet end and a bulb bellows at the other end enables one to inflate the stomach in order to allow free play of the foreign body and to improve the maneuverability of the magnet. The use of such a magnet in the stomach should all but obviate the necessity of cutting through the abdominal wall into the stomach to remove magnetizable foreign bodies.

A second model of the magnet for use in tracheobronchial work, a cylinder 4 cm. in length and 0.3 cm. in diameter, was announced in March 1945. This model is attached to a ureteral catheter for use in intra-bronchial work.

A number of cases of removal of an open safety pin by means of the Alnico magnet have already been reported. If the pin is in the esophagus with the point up, and it always is when in the esophagus, the magnet, introduced through a laryngoscope, is used to pull the pin down into the stomach. When the foreign body is in the stomach, the stomach is inflated and the Levin tube is manipulated until there is a complete reversal of the position of the pin with respect to the magnet. Once this is effected, the magnet is withdrawn rapidly, bringing the pin with it, point down. The trailing point causes no damage to the lining of the esophagus.

In order to improve the fluoroscopic guidance so necessary in this type of work and to simplify taking films, a frame to support the patient, such as has been used in various bronchoscopic clinics for a number of years, has been modified by substituting a plastic plate for the top. It was further modified by tunneling under the plate so as to permit the insertion of a cassette from the side. With this arrangement, it is possible to take a film with a radiographic tube 36 inches above the cassette.

Formerly, with an open safety pin in the esophagus, it was necessary to grasp it with forceps and push it down into the stomach, where it was most difficult to reverse the pin and there was danger of perforation. An alternative was to close the pin in the esophagus; but this could rarely be done, and when accomplished it resulted in considerable trauma to the organ. Even in the most expert hands children who swallowed open safety pins sometimes died. It is in this field, therefore, that the magnet has proved of greatest use: it converts a difficult operation with a fairly high mortality into a simple one almost devoid of danger.

It is appropriate here to voice a word of caution with regard to foreign bodies in the stomach. It has long been recognized that most things that can enter the stomach through the natural channels without harming them can pass out through distal channels equally harmlessly. Before the days of the magnet the removal of foreign bodies from the stomach was very difficult; therefore, when such an object had entirely entered the cavity, one had the choice of attempting to remove the object with Tucker's flexible forceps, performing a laparotomy, or waiting watchfully. The use of Tucker's flexible forceps requires a great deal of experience in addition to skill. Laparotomy always carries some risk, and it was, therefore, usually justifiable to be conservative. The disadvantages of the conservative policy, however, were brought vividly home to me recently. A small child, who had swallowed a bobby pin three days earlier, was admitted to the infirmary. The pin had already entered the duodenum. Two days after admission, symptoms of upper intestinal obstruction developed, and a major operation was necessary to save her life. Remember, then, aside from the danger of perforation of the gut by sharp or pointed

objects, a long metallic one offers dangers of obstruction until it is passed.

### Summary

The Alnico magnet greatly simplifies the removal of ferrous foreign bodies, such as pins, safety pins, staples, screws, nails, tacks and zipper fragments, from the food and air passages.

The magnet is small enough to be passed easily through a 4 mm. bronchoscope. It requires no wires or batteries. The magnet is of no help in the extraction of vegetable matter, or articles of silver, copper or plastic from the esophagus, lungs or stomach.

In removing metallic foreign bodies from the lungs, difficulty is often experienced in grasping with forceps an elusive object such as various types of pins, especially when the point is up. There is always danger of trauma with perforation of the bronchial wall as a result of manipulation.

With the stomach inflated, the removal from it by means of the magnet of ferrous foreign bodies is so satisfactory that it should obviate major surgical operations in almost every case. It is such a simple procedure that one is justified in removing even those objects that would almost certainly pass through the natural channels, if only to spare the patient, or more often the patient's mother, hours of watchful waiting and anxiety. It is in most cases safer, rather than wait in hopes that the foreign body will pass, with the attendant danger of perforation and obstruction, to insert the magnet, withdraw the offending object and send the child home the next day.

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The Medical Association of Georgia will hold its next annual meeting at the Bon Air Hotel, Augusta, April 22-25, 1947.

### DISCUSSION OF SYMPOSIUM ON RESPIRATORY PROBLEMS

DR. ROBERT MAJOR (Augusta): It would be a great pleasure to pay my respects at length to all the papers in this symposium. Obviously, however, it would be wiser for me to confine my remarks to certain meeting points with thoracic surgery.

First, I would like to congratulate Dr. Abbott on his very admirable results with lobectomy for bronchiectasis. This is an enviable record. As for the rest of his paper, I can say only that we are in hearty agreement and that I am very happy that he has emphasized, along with the surgical aspect of bronchiectasis, certain other very significant factors of which we often lose sight.

Dr. Hobby, in his paper, alluded briefly to the prophylactic use of penicillin in preparation of patients for surgery and post-operatively. We have been impressed by our experience with pneumonectomies done for supuration, either total bronchiectasis or multiple abscesses, even though the number is too small for statistical significance. There have been fifteen such pneumonectomies during the past two years at the University Hospital, six before and nine since routine use of penicillin systematically and in the pleural cavity. Among the first six, there were two empyemas, one considered inevitable. Among the later nine, there were no empyemas, although two patients would have been expected to develop intrapleural infection inevitably without penicillin.\*

Dr. Walker very ably presented the superior sulcus tumor. In the presence of bronchiogenic carcinoma and any significant component of the Pancoast syndrome, the utter uselessness of surgical exploration has long been established. Dr. Walker has emphasized pain as the chief problem. While extensive posterior rhizotomy is successful in relieving the pain, it leaves a useless arm. An important contribution is the medullary tractotomy of Dr. Henry Schwartz of St. Louis, in which he divides the spinothalamic tract at the level of the inferior olive. In a recent personal communication he tells me that he has been comparing the results of higher section at the level of the midbrain, as described by Dogliotti in 1937 and 1933, with his probably safer medullary approach.

Dr. Equen's contribution to the safer and easier removal of metallic foreign bodies from the air and food passages has been widely acclaimed and I add my congratulations.

DR. DOUGLAS R. VENABLE, (Columbus): Dr. Walker always gives his audience much food for thought. I must confess that he has called attention to a very interesting pathologic entity that I knew very little about until he aroused my interest in the occurrence of the superior sulcus tumor. It would seem that at least some of the cases reported in the rather meager literature on the subject were not bronchiogenic carcinomas. The great majority, however, undoubtedly fall into this latter category, as does the case he has so well presented this afternoon.

In studying the section from the tumor in Dr. Walker's case, very courteously supplied to him by Dr. S. H. Colvin, Jr., pathologist at Touro Infirmary, at the request of Dr. Dixon of the Ochsner Clinic, New Orleans, one is again impressed by what has been repeatedly observed in nearly all sections from bronchiogenic carcinomas, and that is the pleomorphism exhibited in the neoplasm. It is small wonder that pathologists so often disagree as to exactly which classification a given tumor belongs. In the present case most of the cancer cells are quite large with large round or oval vacuolated nuclei. Then there are huge giant cells that have obviously been formed by the fusion of a number of carcinoma cells. Also there are smaller cells with more deeply basic staining nuclei and rather prominent nucleoli. Mitotic figures are present but are not a conspicuous feature.

\*One patient, sixteen days post-operative at the time of this discussion, subsequently developed empyema and required drainage.



For the most part these tumor cells form solid masses of irregular shape with no evidence of any structural formation. In some areas, however, acinus formation is at least suggested but never complete. Then, as in most of the bronchiogenic carcinomas that I have studied, there are wide areas of complete necrosis, and still others in which there is heavy infiltration by inflammatory cells, largely polynuclear leukocytes. Lobar pneumonia often supervenes in these cases, causing the involved lung to become more solid than would be the case from the carcinomatous involvement alone. In a case that I reported before the Southern Medical Association at Richmond in 1942, there were areas of both squamous cell and adenocarcinoma, with most of the metastases being of the latter variety.

Dr. James Ewing, that old master of beloved memory, gives the following classification for bronchiogenic carcinoma: (1) Carcinoma of Lining Epithelium: (a) Squamous Cell; (b) Cylindrical Cell; (2) Bronchial Carcinoma Arising From Mucous Glands—Adenocarcinoma; (3) Carcinoma Arising From Pulmonary Alveoli: (a) Cuboidal; (b) Cylindrical; and (c) Squamous Cell. Most observers believe that the Pancoast tumor arises from the bronchial epithelium in most cases. Now since the mucus glands of the bronchi arise from specialized lining epithelial cells, it should not seem strange that different types of carcinoma are found in the same tumor. Some add another classification to those already enumerated, the "oat-cell" carcinoma, with cells still more undifferentiated, and hence even more malignant. It is my belief that the superior sulcus tumor differs only in symptoms produced from bronchiogenic carcinomas arising in other portions of the lung.

DR. S. C. LYNN (Savannah): The symposium this afternoon represents many years of experience and observation. All I can do is to re-emphasize some of the points brought out.

The first paper, by Dr. Hobby, is exhaustive in its study. The paper impressed me once more with the fact that we have made epoch-making discoveries in the form of sulfonamide, penicillin and possibly streptomycin. These discoveries are not just one in a century but are so fast in coming that proper utilization of these chemicals in their many ramifications requires constant vigilance on the part of clinicians to obtain the best results.

An excellent point was brought out by this paper on the promiscuous use of pulmonary lavage. The procedure is dangerous because it could transport infective material into normal areas of the lung. Even in instillation of iodized oil, either for bronchographic or therapeutic purposes, the procedure should not be used in the presence of an active infective process anywhere in the lung because there is too much chance of spreading the disease.

The fungus infection is another subject which Dr. Hobby makes very interesting, and I feel that we should make more proper and correct diagnoses in this disease. My experience in this disease is very limited, but I dare say too many diagnoses of fungus infection are made based solely upon the finding of fungi in the tracheobronchial discharge. This finding alone cannot establish a diagnosis. I am emphasizing this point for I have seen patients suffering from decompensated heart, bronchial asthma, and bronchiogenic carcinoma diagnosed as fungus disease. A diagnosis based entirely upon the report of the finding of fungus in the sputum examination, without the inclusion of even one x-ray study, could not be a correct diagnosis in this application.

We have come to the place where one is almost apologetic in taking care of a tuberculous patient and it is not at all inappropriate to reconsider tuberculosis in private practice. I thank Dr. Aven for bringing up this subject. We have 800 or more known tuberculosis cases in Savannah at all times and about 50 at the most are admitted at one time at different sanatoriums. Who is

going to take care of those 750 outside of the sanatoriums? The answer is obvious: practitioners, of course.

We have some up-to-date, well equipped and well staffed sanatoriums in this State and they do outstanding and commendable work, comparable to the best in the world. Then again, we have sanatoriums which are absolutely a disgrace to the intelligence of the tuberculosis specialty. They are not practicing medicine. They are playing politics, for selfish reasons, with the lives of patients and with the money people willingly but unknowingly give.

The name sanatorium or a tuberculosis clinic itself is not a cure-all for tuberculosis. Until individual practitioners share the responsibility of tuberculosis care, the problem of tuberculosis control is not going to be solved. Thirty years ago most states predicted the wiping out of tuberculosis in 20 years with their all-out state tuberculosis control programs. There are still some such advocates. There is no other disease which is any more under federal, state and city control than tuberculosis, but we have more T. B. now than ever before. Therefore, the Do's and Don'ts brought out by Dr. Aven are very important in the solution of this problem.

Since the advent of thoracic surgery there has been renewed interest in pulmonary carcinomatosis, especially bronchiogenic. A few years ago all these cases would have been 100 per cent fatal. Now the story is different. If the diagnosis is made before the onset of metastasis, complete cure by surgery is a well-established procedure, but early diagnosis is absolutely essential. In case of the superior sulcus pulmonary tumor, or Pancoast syndrome, as Dr. Walker's paper attests, it is difficult to make an early diagnosis, mainly because of location of this tumor. If a small density produced on an x-ray film by the atelectatic lobule which in turn was caused by occlusion of the supplying bronchiole due to the bronchiogenic tumor, it will be easily interpreted as tuberculosis because tuberculosis is a more prevalent disease. Also the location is beyond the reach of bronchoscopic examination, either for direct visualization or biopsy purposes, further hindering the diagnostic procedure, and by the time Horner's syndrome develops the tumor is beyond the question of removal. So it seems under the present conditions we are more or less forced to find these cases well advanced, but I believe if we are reminded of the existence of such condition as the Pancoast syndrome often enough, we may be able to help sufferers of this disease more than we are now.

Foreign bodies, especially the removing of them from the body, is always a fascinating subject. A carpenter walks up and down tall ladders with his mouth full of nails, which by as simple an accident as the shaking of a ladder may find their way into his esophagus by the swallowing reflex. Big bill boards on the highway show pictures of a child throwing a peanut into the air and catching it in his mouth, and occasionally the peanut is inhaled into his tracheobronchial passage. The busy mother carries safety pins in her mouth, teaching by example her little ones this bad habit. These also find their way into food and air canals. Obviously objects like the open safety pin would be doubly hazardous, especially when swallowed with the open end upward, and in such cases extraction is not amenable. At this point our own authority, Dr. Equen, came in and solved the problem with his own ingenious invention and the use of the magnet.

DR. JOHN L. JACOBS (Atlanta): I would like to thank the other speakers and discussers for their most interesting papers and comments and to make just one remark in relation to Dr. Abbott's paper on bronchiectasis. While I discussed only asthma in children, the same conditions and diseases must apply to a considerable extent in chronic asthma in an adult, which often leads to bronchiectasis. One often finds bronchial dilatation and weakening of the bronchial walls combined with, no doubt, infection and considerable pathologic changes in the mucosa. I imagine that there must be a good many

of these cases that are not susceptible to surgery and I would like to hear Dr. Abbott's comments and discussion as to their treatment.

DR. OSLER A. ABBOTT (Atlanta): I would like to mention my appreciation to Dr. Major for his very kind comments, as well as the remarks of the other discussants, and state my enjoyment and interest in the other papers given in this symposium.

Dr. Jacob's question in regard to the treatment of patients with true asthma and bronchiectasis is certainly one of the most difficult problems with which one has to deal. We are all familiar with the palliative procedures such as bronchoscopic aspiration, desensitization, autogenous vaccine, and postural drainage. Each case must be considered individually and the degree of bronchiectasis evaluated in relation to the amount of remaining normal lung tissue, and in relation to the condition of the remainder of the lung tissue as regard to emphysematous change. If the vital capacity is within reasonable limits, the removal of the diseased tissue has been known to relieve the symptoms of bronchiectasis, as well as the asthmatic symptoms in several cases. In view of the work of Reinhoff, concerning denervation of the lung by resection of the vagus branch of the posterior wall of the bronchus, it is my policy in resectable cases associated with true asthma, to section this branch as an adjunct to the operative procedure. In occasional cases which are not resectable, bilateral vagotomy can be considered. It should, of course, be stressed that one must not confuse the asthmatic seizures of pure bronchiectasis with a combination of the two diseases. However, I am sure that the cases which Dr. Jacobs has in mind are those in which a major surgical procedure would be contraindicated, and for this type of advanced case a thoroughly satisfactory form of treatment is not at present at hand, although many will be benefited by bronchoscopic aspiration, combined with systemic chemotherapy and aerosol penicillin. These cases constitute a serious and important problem, and it is regrettable that a more satisfactory answer is not obtainable at present.

DR. JOHN E. WALKER (Columbus): I merely wish to say that I enjoyed all the papers. I want to thank Dr. Major, Dr. Venable and Dr. Lynn for their very kind discussion of all the papers.

#### MUSTARD GAS STUDIED AS ANEMIA TREATMENT

A chemical agent which would have about the same effect as x-radiation on neoplastic tissue—the tissue of such malignant growths as cancer—has been sought for some years by medical investigators.

One now appears to have been discovered in a curious way. Although as a means of therapy it appears to have no particular advantage over x-radiation and in some ways is decidedly inferior, it is of great interest as the first material with some capacity for selective destruction of neoplasms to appear, and considerable research on its properties now is underway. It is of great significance, at least theoretically, as an opening wedge into a possible new field of medicine.

One of the terrors of the first World War was mustard gas. While this was not used by any combatant in the second World War, it naturally was studied by all the countries involved and improved forms were produced. Among these, both in the United States and Great Britain, were the so-called "nitrogen mustards." Their precise effects on the human organism were investigated in order to devise adequate defenses and proper medical treatment in case they were introduced by the enemy. They were found to produce profound anemias due to their specific effects on lymphatic tissue and bone marrow where blood cells are formed. The effect was very similar to that caused by heavy x-radiation.

This finding led to the possibility that, used in rigidly measured doses, they might actually be used as medicines for blood and lymph neoplasms. They are very

potent poisons. The problem is to administer them by injection in such balance that they will do much more harm to unwanted tissue than to surrounding healthy and normal tissue. This also is the problem with x-ray treatment.

Experiments have been carried out in several institutions in order to obtain a fair evaluation of the nitrogen mustards before they are accepted as recognized medicinal agents. Among these institutions is the New York Memorial Hospital. The results have just been reported in a paper submitted to the War Department Surgeon General's Office by Captain D. A. Karnofsky of the Army Medical Corps who worked in cooperation with Drs. L. F. Craver, C. P. Rhoads and J. C. Abels.

The agents were used in treatment of several types of malignant anemias. In one type they proved quite successful. The results were comparable with those that would have been expected from x-radiation. This was Hodgkin's disease, characterized by severe enlargement of the lymph nodes and the spleen, accompanied by a profound anemia which eventually proves fatal. The malady is rare, but has been known for about a century. Altogether 28 patients with this disease were treated at Memorial Hospital, Captain Karnofsky reports. Three, in whom the condition was caught in its early stages, received no other treatment from the first. The others had received x-ray therapy. It was found that there were conspicuous beneficial effects. After each treatment there was temporary alleviation of the weakness, fever and loss of weight ordinarily associated with Hodgkin's disease. There was an improvement in general well being. Anemia was improved in two relatively early cases, but there was no improvement in patients with severe anemia in advanced stages of the disease. There is no reason to believe that any cures have resulted from this therapy but life has been prolonged similar to that after x-ray therapy.

Transient regressions were obtained in cases of lymphosarcoma, a malignant growth of the lymph nodes, but the progress of the disease was not materially affected. Five of those treated were dead within 11 months of the recognized onset of the malady. The remaining patient, a year after the onset, is now in very poor condition. Other malignant maladies showed little improvement.

Nitrogen mustard, concludes the report: "is a chemotherapeutic agent with activity against certain forms of neoplastic disease. Under present methods of therapy, however, it offered no therapeutic advantage over properly used x-rays. In fact, x-rays were ordinarily to be preferred. In certain cases of Hodgkin's disease with generalized systemic symptoms for which x-ray treatment was no longer feasible or effective temporary symptomatic remissions were induced. The general use in preference to standard methods of x-ray therapy is not recommended until the therapeutic indications and limitations of this new agent are more precisely determined by further clinical studies."

#### HYPERTENSIVE PATIENTS MUST BE RELIEVED OF FEAR AND ANXIETY

*Doctor States "Moderation" Should Rule Life of Patient  
In Order to Avoid Increase in Arterial Pressure*

"One of every three deaths would be postponed, years of worry, economic dependence and illness would be renitied if arterial hypertension (high blood pressure) and its related diseases could be abolished," according to an article in the current issue of *Hygeia*, health magazine of the American Medical Association.

The authors—Irvine H. Page, M.D., associate member of the Rockefeller Institute and director of research for the Cleveland Clinic Foundation, and A. C. Corcoran, M.D., a staff member of the Rockefeller Institute Hospital who specializes in the physiology and pathology of high blood pressure and kidney disease—state that as yet the causes of this condition are still unknown. However, it has been recognized that hypertension occurs in the course of such diseases as Bright's disease, inflamma-



tion of the kidney and tumors of the adrenal glands.

The problem of arterial hypertension has two major facets, the first being the removal of the causes of increased pressure and the other the arrest and prevention of vessel damage. Drs. Page and Corcoran believe that one observation in animals has greatly stimulated research on this problem. "This was the demonstration that partial clamping of the artery which nourishes the kidney results in a persistent increase of arterial pressure that mimics the arterial hypertension of human beings. This clamping sets up a disturbance in the flow of blood through the kidney which stimulates the liberation from it of a substance called renin. Renin interacts in the blood with another substance to liberate a third compound, angiotonin. Angiotonin, or something chemically like it, then contracts the arterioles and increases the heart's effort. The result of its action is a sustained elevation of arterial pressure. Some evidence indicates that long-established experimental hypertension of this sort causes arteriolar damage of the type which may develop in human beings.

"This accounts for the hypertension that may complicate certain types of kidney disease. It may also be the cause of some of the increase in pressure in patients with arterial hypertension whose kidney vessels are damaged. Damage to the arterioles of the kidney, although common in established and severe hypertension, is not found in the early and mild forms of the disease. It is still rather unlikely that we have accounted for the first elevations of arterial pressure in human beings."

There are certain general measures that can be taken to relieve hypertension. Among these are the avoidance of unpleasant emotions such as fear, anger or anxiety which may temporarily increase arterial pressure; moderation in diet and, in the presence of obesity, deliberate, slow reduction of body weight to a level preferably a little less than normal for the patient's height and age.

Operations are performed for the relief of arterial hypertension. They consist in severing many of the nerves which stimulate blood vessels.

#### RAGWEED CAMPAIGNS OF LITTLE HELP TO HAYFEVER SUFFERERS

Community campaigns to eliminate ragweed for the relief of hayfever sufferers are virtually a waste of time and effort, according to the September 7 issue of *The Journal of the American Medical Association*.

"A. Harmon, N. Y., physician informed *The Journal* that Croton-on-Hudson, N. Y., which covers approximately 10 square miles, is contemplating a depollinating program and he asked if such a campaign were feasible and practical for a community of this size. *The Journal* replied:

"The answer does not depend on the size of the community but on its situation. If a community is insulated on all sides with a wide strip of water or forested land, the size of the city makes little difference. Croton-on-Hudson, N. Y., is not favorably situated because of the adjacent cultivated areas. Ragweed pollen would be blown into the city from farm lands in northern New Jersey even if every ragweed plant in the city should be destroyed.

"Permanent riddance of ragweed from any community in which it is well established is well nigh impossible, because of the longevity and abundance of viable seeds in the soil. Annual riddance can be best accomplished by uprooting the weeds, but recent experiments have shown that chemical destruction is entirely feasible. However, it must be noted that complete destruction of the weeds during one season will not appreciably affect the presence of weeds the next season, nor will complete destruction of ragweeds before the time of shedding of pollen prevent toxic amounts of pollen being blown into the community from areas as far away as 50 or 75 miles.

"Apparently successful weed destruction campaigns have been carried out in a few places, but in only one

instance have control tests of the air been made before, during and after the campaign in order to determine its effectiveness. In Sault Ste. Marie, Mich., and Bar Harbor, Maine, in past years local efforts have been directed toward ragweed destruction and have been deemed successful, though no atmospheric tests were made. Since both these places are fairly well insulated it should be possible by diligent weed destruction to reduce the pollen content of the air very considerably. In Chicago, control tests carried on during a three year campaign showed a higher total pollen content of the air each year during which the campaign was carried on. There is no hope of reducing the pollen content of the upper air by local weed eradication in a community surrounded by millions of acres of ragweeds in farm lands."

#### BRUCellosis EASILY MISTAKEN FOR OTHER INFECTIOUS DISEASES

Brucellosis, also known as undulant fever, is a difficult disease to diagnose because psychoneurosis may mask the original symptoms, according to Harold J. Harris, M.D., of New York.

Writing in the August 31 issue of *The Journal of the American Medical Association*, Dr. Harris points out that "it is almost as easy to mistake psychoneurosis for brucellosis as it has been to commit the opposite error in the past, i.e. to diagnose actual brucellosis as psychoneurosis. The subjective complaints are likely to be very similar in the chronic illness."

Psychoneurosis usually develops because the disease is characterized by marked invalidism and slow convalescence.

The difficulty of diagnosing this infection is further illustrated by the fact that the disease does not show characteristic symptoms and therefore when the patient has persistent fever, sweating and complains of great fatigue and joint or muscle pains, there is reason to suspect the presence of an infectious disease such as typhoid or malaria.

Cows, hogs and goats harbor the *Brucella* bacteria and man contracts the infection by drinking raw milk or handling infectious material. The disease rate among veterinarians in Iowa, according to an investigator cited by the author, was 250 annually per 100,000 between 1942 and 1945. The only higher rate was among packing house workers, who had a rate of 271.5 per 100,000. By way of comparison, the rate for farm workers was 43 per 100,000 and for urban groups of merchant and professional men 3.3 per 100,000.

The author emphasizes the importance of early diagnosis, especially in animals, stating that "failure of early diagnosis in man is of less importance to his fellow man than such failure in the animal kingdom. As far as is known, human beings do not directly transmit infection to other human beings, nor do they serve as reservoirs of infection for the indirect transmission of infection. The undiagnosed infection in the animal is almost limitless in its potential danger to other animals, and thence to man."

Dr. Harris states that the "treatment of brucellosis is likely to be a tedious, arduous task for both the physician and patient but is usually successful in bringing about recovery if not permanent cure." He maintains that "five years of freedom from all manifestations of illness probably should be the minimum period which must elapse before even the reasonable hope of cure should be entertained. Reports on cures after six months or less of observation, which are so frequently seen in the literature, are often responsible for the perpetuation of many useless ideas about treatment."

In evaluating several treatment procedures the author contends that neither penicillin nor the sulfonamides give promise of being curative while streptomycin is only effective in terminating the acute illness. However, a relapse usually follows the use of this drug. A vaccine serves as the most effective treatment to date for the uncomplicated chronic infection.

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**DIRECTORY OF THE ASSOCIATION**

In this Journal is printed the directory of the Association. In addition to the usual listing of names under county medical societies, all names of members of the Association have been listed alphabetically.

This compilation of the directory represents a tremendous amount of work. More work will be required to make the directory correct in every way, for the reason this year of 1946 was a postwar year. The dislocations of war affect all peoples, and physicians as well. Examine the directory for your name and address. If these are not correct, please notify the office of the Secretary-Treasurer.

Each member of the Association should realize that he or she is a part of the American Medical Association and that the records of that organization will not be correct without full cooperation of this Association. Also each member of the Association should realize that his or her good standing must be maintained at all times in order to participate in the work of the various national medical organizations.

**CURRENT TRENDS IN MEDICAL CARE**

Medicine today is in a stage of rapid evolution, accelerated by the phenomenal growth of medical knowledge during recent years and by growing public concern over the health of the population as a whole. In the long-term over-all appraisal of the resources of our nation, there is general agreement that the health and vigor of the individual and of the entire population are vital assets of the entire country, as well as the concern of every citizen and family. The contributions of medical knowledge to the maintenance, protection and improvement of health are widely recognized. Additions to that knowledge have been greater in the last fifty years than in the previous four thousand. At the risk of over-simplifications in such a brief presentation as this, attention should be called particularly to several important current trends of medical care.

Medical knowledge is now so complex and requires so many different skills that no single individual can possibly master the entire field. The development of specialization has been in-

evitable and, within limits, desirable. Complete medical services can no longer be rendered by an individual physician alone. The necessity of cooperation between specialists in the care and treatment of many illnesses and in many phases of individual preventive medicine suggests some form of group responsibility and coordination of the services and knowledge required for the care of a given patient.

Associated with the necessity of some form of coordinated or group practice is the increasing emphasis upon comprehensive rather than limited medical care, restricted usually to surgical conditions and obstetrics which represent only a small fraction of the medical needs of individuals or families. The coverage should be not only comprehensive for the individual but should include the entire family of dependents. Included in such comprehensive services should be preventive medical services, as well as curative and restorative procedures.

It is well to emphasize that the general community hospital of the future will be the base of modern medical service. It must include not only laboratories equipped and manned to provide diagnostic services but increasingly must provide determinations to guide the doctor in the control of therapeutic procedures. It must include an out-patient service for follow-up, rehabilitation, ambulatory and home treatment, much of which if well utilized can relieve the demands for expensive in-patient hospital care. It should gradually provide office facilities for more practitioners who on the basis of "geographic full-time" can greatly increase their effectiveness and service to the community at lowered cost and with greater satisfaction to themselves.

The hospital is the natural center for all forms of professional education of nurses, doctors, dentists, technical aids of every kind, attendants, administrators, and the local general public. In such an environment, research into new methods of diagnosis, treatment and prevention, would flourish. Specialized hospitals for such conditions as tuberculosis, cancer, other chronic, incapacitating illnesses, contagious diseases, mental disorders, and the crippled and handicapped, maintained from tax sources will be needed and should have the facilities and trained personnel to render the highest type of medical services. General hospitals for the indigent are recognized almost universally as the responsibility of local government.

The establishment of sound hospital-group practice units where actually needed throughout the country will have a particular bearing on the all important question of the distribution of physicians. At present in this country there is one doctor to about 750 persons, an over-all ratio generally regarded as fully adequate if the



services of such trained personnel are available when needed. The ratio is two to five times that found in any country in the world previous to the war. The output of the existing medical schools of the country will maintain and even increase that favorable ratio. The problem of providing proper medical services for the population is not that of producing more physicians but of obtaining a better distribution and utilization of existing doctors and future graduates. The solution is in the creation and proper maintenance of hospital centers, wherever the local health needs justify such units.

Young medical graduates, nurses and other trained professional workers will not go into practice in small communities or rural districts unless modern facilities for practice are available. Until such opportunities exist or are created, financial subsidies or other inducements alone will not suffice. It is in such institutions also that the younger graduates can be more effectively utilized than they are today. Perhaps the greatest waste of medical manpower in our present scheme of medical services occurs in that period of from five to ten years after completion of hospital training when younger physicians are only partly occupied in the early stages of practice.

Mention should be made of the program of the Veterans Administration which is now charged with the responsibility for certain types of medical care for over 19,000,000 ex-service men and women. Should future Congresses extend the existing provisions to non-service connected disabilities and to the dependents of present beneficiaries, there will be a potential 60,000,000 persons involved. These possibilities make most urgent the earliest possible development of sound, community-wide programs of medical care for the entire population.

Group practice or any other scheme of medical care cannot be entirely satisfactory without full consideration of at least two crucial elements in any plan. The first is the maintenance of a high quality of medical service which in the last analysis is dependent upon the qualifications and training of the personnel itself (doctors, nurses, dentists, technicians, social workers and others). The second is that no matter how the services are organized, the delivery of these medical services must be upon an individualized basis for the obvious reason that health problems are those of individuals.

In appraising the needs for medical care, it is important to keep in mind that the character of medical services in this country has changed appreciably in the past twenty-five years. A generation ago a large part of the problem was the control of contagious diseases which attacked particularly children and young adults (diphtheria, typhoid fever, tuberculosis, smallpox, and

the diarrheal diseases of children, as examples). Many of these causes of death and illness have now been brought under control or practically eliminated. Thousands of individuals now live to middle or old age as a result of the control and prevention of these crippling and killing diseases of early life, which explains in large part the sharp alteration in the age distribution of the population. Today the major problems of medicine are those of middle and later life, of chronic diseases, early diagnosis and preventive therapy, the correction of disabilities, often chronic, and the rehabilitation of handicapped individuals through vocational, psychological, educational and medical treatment.

Illness is unpredictable for the individual and is highly uneven in its distribution in the population. In rough figures, fifty per cent of the total cost of medical care is at present carried by about ten per cent of the population. Perhaps four per cent of the families of the country bear more than one-half of the total cost of hospitalization and surgical treatment. On the other hand, the total cost of adequate medical services is not high in comparison with other expenditures in the national economy. The problem involved is that of spreading the total cost of medical care over a long fraction of the total population and over a long period of time. This involves the principle of insurance, so widely recognized in this country in other than health fields and first enunciated in the area of social security in the French Convention of 1794.

The program of insurance against sickness and the results of incapacitating illness for self-supporting persons is recognized everywhere as only a part of the larger social concept. It represents a part of the effort of employed persons for security, particularly for the wage earner, which also includes protection against such risks as old age, provisions for widows, orphans or other survivors, temporary or permanent disability, unemployment, maternity benefits and more recently, hospitalization to which the employed person is liable. Originally, the object was to distribute the purely economic burden of illness over a large segment of the population. This consisted of payment for time lost and led to the development in the health field of "cash benefits" for illness, disability and unemployment because of illness. This was shortly supplemented by "benefits in kind" comprising largely provisions for restoration, treatment and the cure of sickness and injury and not just compensation alone. More recently the emphasis has been increasingly placed upon prevention.

Since the inauguration of various voluntary plans for collective provision of medical services, a number of nation-wide experiments have been tried in Western Europe, especially during the last sixty years. It is interesting to note that

many of the present recommendations and efforts of the medical profession and other groups in this country in dealing with prepayment medical programs have ignored or disregarded the actual experiences abroad. As an example, the proposals by the medical profession for medical care insurance are on a "cash benefit" basis for partial medical services on a fee-for-service remuneration rather than on the provision of comprehensive "benefits in kind". These methods are quite contrary to the best experiences and evidence here and elsewhere that would indicate that the proposals are already known to be impractical and unworkable.

Many of the policies being written by medical society programs are almost identical with the policies written by the commercial casualty indemnity companies. It is difficult to see why the medical profession is entering into a field of indemnity insurance already covered expertly by some of the leading insurance companies in this country. The only justification for the medical profession entering into the insurance business is to provide "benefits in kind" in the nature of comprehensive, adequate medical services, leaving the cash indemnity business to the commercial companies.

Another consideration of importance is that of the administrative responsibility in the conduct of prepayment medical services. The medical profession insists upon the control of any medical service program. It is obvious, however, that the responsibility for providing adequate medical care for the country is not merely a professional responsibility. Any adequate plan must embrace the interests of labor, business and the public as well as the professional groups. Industry, banking, labor, the medical and other professions, the hospitals, public administration and other interests should be represented. The purely professional matters must, of course, be left in the hands and to the judgment of the doctors and other professional workers who by training, skill and experience are qualified to make the best decisions regarding professional services.

It is important to emphasize that local administration of a program is essential to full success. Only through actual local direction will it be possible to adapt medical service plans to meet the needs of individuals and of the community in which these services are to be rendered.

Medicine today is as much a social as it is a biological science. The doctor is not merely a technician but must be an important factor in the shaping and guiding of any satisfactory plan of medical service. It has been quite apparent in recent years that the medical profession, so largely concentrating on individual techniques and methods of practice has failed to produce long-term, constructive policies or a sufficient

number of public minded leaders who are qualified by point of view or experience to guide the development of sound local and national plans for medical care.

The country needs wise, courageous leaders in medicine, cooperating with industry, labor and the public to meet the health needs of the country and avoid the errors and mistakes of other health service programs such as have been developed in the last sixty years in Europe. We must develop plans which will be suitable to the needs of American society under the guidance and direction by professional personnel on professional matters. There is every reason to believe that with patience and consideration of the complex adjustments that have to be made in the development of a medical service program adapted to the needs of present-day society, the medical profession will be able to make a contribution of the greatest importance to the welfare of the country. If the profession is prepared to provide the necessary leadership and guidance, there is every reason to suppose that in substantial measure it will be able to remain in the position of determining the broad, over-all professional policies.

WILLARD C. RAPPELEYE, M.D.

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#### ABLE-BODIED VERSUS DISABLED

The vast number of American industries that employed handicapped workers during the war discovered that their absentee rates, turnover, and accident rates were lower than for able-bodied workers performing similar duties, it was revealed by Veterans Administration and Retraining and Reemployment Administration.

These facts, results of a survey conducted by the U. S. Office of Education in 1943, were disclosed in an effort to enlist public support for "National Employ the Physically Handicapped Week," Oct. 6-12, 1946.

During the war, 83 per cent of the nation's industries employed disabled workers.

Of 97 employers who reported on absenteeism, 53 said that disabled workers lost fewer days than able-bodied, 39 found absenteeism the same for both groups, and only 5 said handicapped employees lost more days than the able bodied.

Sixty-three of the 76 employers who reported on labor turnover said the turnover rate was lower for the handicapped, 12 found it to be the same for both groups, and only 1 reported it higher for the disabled.

Of 87 employers who reported on accident rates, 49 revealed a lower accident rate for the handicapped, 36 found similar rates for both groups, and 2 said the rate was higher for the handicapped.

The Office of Education surveyed more than 100 employers, most of them executives of large corporations engaged in manufacturing war materials.

Although United States Employment Service gives specialized assistance to disabled employees, a recent USES report revealed that only one out of every five handicapped veterans applying for work at public employment offices found a job during the first half of 1946.

Of the total number of disabled workers placed by USES, 75 per cent are veterans.



## GEORGIA DEPARTMENT OF PUBLIC HEALTH

## IMPORTANCE OF SAFE MARKET MILK

Ancient history tells us that the cow was frequently made an object of veneration and worship. She has been called the "foster mother of the human race"—a title which she has fairly earned, for no other animal has done so much to nourish the human family. Her product is milk, a food provided by nature for promoting growth in the young.

"Market milk" is a term applied to milk consumed in its fluid state, in contradistinction to milk used for manufacturing products such as butter, cheese, ice cream, etc. Far more milk is consumed in the fluid state than is used for any other purpose. It is used in this form upon almost every family table; it is the chief food of infants and growing children, and is also used by adults, and is especially useful in the diet of sick persons and those undernourished.

The production and handling of market milk requires sanitation and the highest type of scientific skill. Market milk must be produced economically and marketed expeditiously; from cow to consumer it must be carefully guarded by sanitary measures on account of its susceptibility to infection.

Originally milk was consumed close to the source of production; the cow supplied the needs of her owner's family, with perhaps a small surplus for neighbors. Gradually civilization became more complex and people clustered in cities, thus forming groups of "non-producers" of foods, responsibility for production resting upon the remaining agricultural population. As cities grew, dairying was pushed farther away from the markets, so a system had to be evolved to transport and distribute milk from the dairy farm to the consumer.

The introduction of the time element between production and consumption, together with increased complexities in handling the milk, necessitated a rather elaborate system of sanitary control which called into play all the resources of the sanitarian and the bacteriologist. These factors, in connection with the magnitude of the business, have made the market milk industry one of the most highly specialized in food production.

Milk affords more nourishment for the human body than any other food. Since milk is such an important food there is need to be sure that it is produced under conditions which will protect its safety, wholesomeness, and natural flavor. Milk is the only food specifically prepared by nature for the young of mammals. With this in mind, dairymen and the milk industry are cooperating with state and local health authorities in setting up standards to protect the high quality of the product and to assure continued good markets.

The market milk sold in the United States may be divided into two classes, raw and pasteurized. Pasteurization is defined as the process of heating milk to at least 143° F. and holding it at that temperature for 30 minutes, or heating it to at least 160° F. for 15 seconds in approved and properly operated equipment. This latter process is a later development.

It is believed that pasteurization, when properly done, destroys at least over 99 per cent of all disease-producing organisms in milk, and its keeping quality is improved. Recent pasteurization research on high-temperature-short-time (H.T.S.T.) has revealed no less of ascorbic acid (vitamin C) and only 3 per cent loss of thiamin (vitamin B<sub>1</sub>). Even so, any vitamin C deficiency may be compensated for by citrus fruits and their juices, raw or canned, tomatoes and other vegetables, and vitamin B<sub>1</sub> by lean pork, liver, legumes, eggs, whole grains, enriched cereals, and bread. In the future, greater emphasis will be placed on high quality milk properly pasteurized.

Occasionally there occurs raw milk-borne outbreaks of serious consequence. Not many years ago there occurred in Montreal, Canada, an epidemic causing over 5,100 persons to be stricken with typhoid fever resulting in over 500 deaths. Therefore, public health workers and the dairy industry must produce and market a milk supply which will not become contaminated by disease organisms of man and animal. Then the goal should be grade A pasteurized milk. Every dairyman and the milk industry generally will find it an advantage to cooperate with health authorities in attaining this goal. This will mean greater consumption and more profit.

Milk consumption in Georgia is increasing greater than is generally realized. Georgia has been considered by comparison a state low in milk consumption. The comparison by states is changing and this should be a contribution to the program of nutrition in Georgia.

The United States Department of Agriculture has recently released a report on milk consumption by states. It does not include milk products but milk used as milk and cream in urban populations and according to the 1940 census. This report shows that for the year 1945 Georgia is among the seventeen leading states in milk consumption, ranking the seventeenth. It is of interest to note these states in order: New York, Pennsylvania, Illinois, California, Ohio, Massachusetts, Michigan, New Jersey, Texas, Missouri, Indiana, Wisconsin, Minnesota, Connecticut, Iowa, Maryland, and Georgia. It is also of interest to note that Georgia outranks such agricultural states as Virginia, Kentucky, Tennessee, and North Carolina. Probably we should not attribute this to a greater population of

Georgia because the populations do not differ greatly and one of these states had a population of 347,900 greater than Georgia. However, this state ranks twenty-first on the list while Georgia ranks seventeenth. It is true that Georgia imports a large quantity of milk but is making considerable progress in home production.

So much for quantity. How about quality? We have no means available to compare the quality of Georgia's milk with that of other states. It is quite possible that we would not be justified in speaking with pride on this subject.

It is common knowledge among milk sanitarians that over the entire nation during the period of war the sanitary quality of milk deteriorated. This was evidenced by lax sanitary conditions of dairy farms and at milk plants and by increased bacteria count. With the ending of the war period and the great increase in milk production it behooves the milk industry and public health authorities to bring market milk supplies up to a higher standard. The state and local health departments in Georgia are working to this objective. A specialized milk sanitation service is rendered by the state department to local health departments. This was augmented on May 1, 1945 by placing into service a mobile milk laboratory to render more effective assistance to local health departments.

Administration of milk sanitation is usually invested in the local health commissioner. The locally adopted milk ordinance generally requires that every firm or individual selling milk must obtain a permit from the health commissioner and that no dealer selling milk can receive it from any other than an approved source. The mobile laboratory is located on an individual milkshed and continued in operation until all dairies on the shed meet the requirements of the ordinance. Sanitation and bacterial requirements are the prime objectives. In addition to inspections and sanitary improvements at the dairies, the laboratory performs temperature tests of milk coming to the plant, sediment tests, and bacterial plate counts. Full advantage is taken of the opportunity to create the interest of the individual dairyman in the methods and objectives of the service and to stimulate public health consciousness. A sediment test performed in the presence of the dairyman proves a very effective demonstration, especially when an excessive amount of dirt is observed. Insanitary conditions at the dairy are called to the attention of the dairyman and he is encouraged to follow through to the laboratory and observe the correlation between the insanitary factors and the high bacteria count. Also literature in the form of bulletins dealing with safe and wholesome milk production is generously distributed to the dairymen.

The educational value of this service cannot be over-emphasized. The present demand for this mobile laboratory service is greater than can be supplied. Consequently an additional mobile laboratory has been purchased and will be in operation when necessary equipment and personnel can be obtained.

Finally, it should be stated and emphasized that milk can be safeguarded so as to prevent it from transmitting such diseases as tuberculosis, typhoid fever, scarlet fever, diphtheria, septic sore throat, undulant fever, and others by careful and sanitary production followed by pasteurization. Neither sanitary production nor pasteurization alone is adequate. Both are necessary to assure the maximum protection from cow to consumer. This means Grade A pasteurized. While milk quantity is increasing in Georgia we should exert every effort to improve its quality.

L. M. CLARKSON, *Director,*  
Public Health Engineering,  
Georgia Department of Public Health.

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#### VETERANS' PROBLEMS

There has been a 29 per cent increase since V-J day in the number of veteran patients in its hospitals and homes and in other hospitals under contract, Veterans Administration announced.

The total on Sept. 12 was 104,612 patients, compared with 81,031 on V-J day.

VA said the biggest increase occurred among World War II veterans with non-service-connected disabilities. The number of such patients rose from 10,333 to 24,437, an increase of 136 per cent.

The number of World War II veterans receiving medical care for service-connected disabilities increased from 11,593 to 17,476, a rise of 51 per cent.

The smallest gain reported was in the number of veterans of other wars and of peacetime service receiving medical attention. They increased from 50,032 to 50,369 a gain of two-thirds of one per cent.

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#### HEALTHGRAMS

From time immemorial man has considered health as his rightful heritage, and has therefore resented disease as a misfortune visited upon him by malignant external influences. Edward J. Stieglitz, M.D., *A Future for Preventive Medicine*, The Commonwealth Fund, 1945.

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Tuberculosis has been a serious problem to the health authorities in every country where war means greatly lowered living standards, extreme overwork, and a governmentally regulated diet which has not yet proven adequate when rationing becomes severe. In England and Germany, two countries in which tuberculosis authorities were questioned, the war presented the ideal set of conditions optimum for the incubation and transmission of pulmonary tuberculosis. There now appears sufficient evidence to warrant the conclusion that this new type of warfare—namely the bombing of city areas for strategic purposes—compounds the problem of tuberculosis in wartime. George A. Wulp, M.D., *The Effect of Bombing on Health and Medical Care in Germany*, October, 1945.



## GEORGIA STATE NURSES' ASSOCIATION

### PLATFORM OF GEORGIA NURSES

MRS. DURICE DICKERSON HANSON, R.N.  
*Executive Secretary, G.S.N.A.*

The fortieth annual convention of the Georgia State Nurses' Association, and allied State Nursing Groups, was indeed one long to be remembered. It was held November 3-6, 1946, at Macon, with the Sixth District Nurses planning and entertaining for this first postwar convention.

Discussions on "Expected Developments in Georgia Nursing" brought out forcibly the urgent need for a definite platform. This platform was adopted and will be in line with the one adopted at the September 1946 biennial meeting of the American Nurses Association, which was briefly described in this Journal November 1946.

Georgia nurses are taking for their first plank in the platform: "Employment of well-qualified practical nurses and other auxiliary workers under state licensure, thus protecting both the patient and the worker."

A tentative bill has been drawn and was presented and adopted by this convention in order to carry out this part of the program. It will be presented at the next session of the Legislature. There is already much interest in and support of this bill.

The following credo was unanimously adopted by the association at Macon, and gives the Medical Association and allied service groups the position of the association regarding licensure of the practical nurse and proposed courses for her training.

#### "CREDO"

1. We believe that through the years practical nurses have rendered faithful and, in most cases, efficient services to the sick.
2. We believe there will be a continuing need for such services.
3. We believe that such services are needed in both homes and hospitals.
4. We believe that an organized course of training should be given for the types and classes of care that can be given by practical nurses.
5. We believe that such courses should be under the direction and supervision of competent instructors, and should operate in accordance with established standards of training and practice.
6. We believe that the board now set up to administer the law governing nursing education and practice should bear the same relations to the training and licensure of practical nurses.
7. We believe that representatives from the practical nurse personnel should serve on this board and have a full vote in all its deliberations.
8. We believe that cooperation and understanding and mutual helpfulness should be established and maintained in the professional relationships and employment practices of all those who care for the sick public.
9. We believe that the facilities and membership of the Georgia State Nurses' Association should be avail-

able to assist in organizing and establishing such working relationships.

10. To that end we pledge our individual and collective efforts.

#### *Georgia State Nurses' Association Committees on Legislation and Auxiliary Service*

The resignation of the executive secretary, Mrs. Durice Hanson, was accepted, effective January 1, 1947. This position will be filled by the executive board.

Mrs. Eugenia Spalding, Professor of Nursing Education and Director of Nursing Education, Indiana University, Bloomington, Indiana; and Miss Eleanor Palmquist, Assistant Director, National Organization for Public Health Nursing, New York City, were national guest speakers. Other state and local guest speakers on the program included: Mrs. James N. Brawner, Sr., Chairman Nursing Education Committee, Georgia Federation of Women's Clubs, Atlanta; Dr. Guion G. Johnson, Executive Secretary, Georgia Conference on Social Welfare, Atlanta; Honorable Charles L. Bowden, Mayor, City of Macon; Dr. A. H. Conner, Industrial Physician, Columbus; Mr. G. Elliott Hagan, Secretary-Treasurer, State Workmen's Compensation Board, Atlanta; Mr. P. A. Springer, Safety Engineer, Liberty Mutuals, Inc., Atlanta; Mr. Dennis Allen, Bibb Manufacturing Co., Macon; Mr. H. Louie Wilson, President, Georgia Hospital Association, Albany; Dr. C. L. Ridley, Chairman, Georgia Board of Health, Macon; Miss Frances Bethune, Southern Field Representative, Employers' Mutual Liability Insurance Co. of Wisconsin, Charlotte, N. C.; Miss Marjorie Massee, Instructor in Diet Therapy, Crawford Long Hospital and Piedmont Hospital, Atlanta; Miss Marion Gutske, Student Nurse, Emory University School of Nursing, Emory University; Reverend Eric A. O'Sterle, Pastor, Tattnall Square Baptist Church, Macon; Dr. Milford Hatcher, Macon; O. D. Knight, Ph.D., Professor of Psychology, Mercer University, Macon; Mr. Buford Boon, Macon Telegraph, Macon; Miss Wilma Van Dusseldorf, Oglethorpe University, Atlanta; Miss Frances Scherz, Family Welfare Society, Atlanta.

The following officers were elected for the Georgia State Nurses' Association: vice-president, Dana Hudson, Atlanta; secretary (re-elected), Mrs. Esther Watts, Columbus; directors, Mrs. Ralph Pope, Gainesville; Mrs. Durice D. Hanson, Atlanta; chairman nominating committee, Elizabeth McClellan, Griffin.

Other officers already in office and continuing to serve are: president, Mrs. Olive L. Barbin, Augusta; second vice-president, Vera Mingledorff, Griffin; treasurer, Jane Van De Vrede, Smyrna; directors, Frieda Grefe, Savannah; Ruth Babin, Atlanta.

The 1947 convention will be held at Savannah. The other organizations did not change presidents. For more detailed information write State Nursing Headquarters, 131 Forrest Avenue, N.E., Atlanta.

#### PENICILLIN MAY CAUSE NERVE INJURY

Two Navy doctors suggest that penicillin may cause injury to the nerves running to the surface of the body with resultant loss of sensation and muscular power, according to the October 12 issue of *The Journal of the American Medical Association*.

Comdr. Lawrence C. Kolb, (MC), U.S.N.R., and Lieut. Comdr. Seymour J. Gray, (MC), U.S.N.R., state that they observed this muscular weakness in seven patients treated with penicillin injections into the muscles at the U. S. Naval Hospital, National Naval Medical Center, Bethesda, Md.

The nerve injury observed in all the cases occurred from 10 to 21 days after the initial injection of penicillin. The number of penicillin injections into the muscles given prior to these symptoms varied from 10 to 72.

The authors point out that complete recovery from the neuritis occurred within four months in five of the seven patients.

## MEDICAL ASSOCIATION OF GEORGIA

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Alternate, H. C. Sauls .....	Atlanta
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*Revision of Pharmacopeia of U. S.*

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W. H. Pirkle	Cochran
J. A. Camp	Roberta
E. A. Hensley	Gibson
C. S. Jernigan	Sparta
F. S. Belcher	Monticello
John R. Lewis	Louisville
Joseph D. Zachary	Gray
John A. Bell	Dublin
George H. Alexander	Forsyth
A. S. Sanchez	Atlanta

Ormond Daniel	Jeffersonville
O. D. Lennard	Sandersville
S. N. Rubin	Gordon

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A. L. Horton	Cartersville
W. B. Hair	Summerville
L. L. Welch	Marietta
C. V. Vansant	Douglasville
Lee H. Battle, Jr.	Rome
J. E. Billings	Calhoun
C. H. Allen	Bremen
Cecil B. Elliott	Cedartown
Frank L. O'Connor	Rossville
H. J. Ault	Dalton

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J. T. Holt	Baxley
T. H. Clark	Douglas
Alton M. Johnson	Valdosta
F. L. Mann	McRae
W. L. Pomeroy	Waycross
J. Alvin Leapart	Jesup

*Ninth District*

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Marcus Mashburn, Sr.	Cummings
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Herbert Olnick	Dahlonega
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John Simpson	Athens
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L. M. Huie	Monroe
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W. J. Cranston	Augusta

*Fraternal Delegates to Other State Meetings*

Alabama: D. S. Reese, Carrollton; Mercer Blanchard, Columbus; R. F. Wheat, Bainbridge.  
 Florida: Wm. W. Anderson, Atlanta; John W. Simmons, Brunswick; Hal M. Davison, Atlanta.  
 North Carolina: Allen H. Bunce, Atlanta; Harry T. Harper, Jr., Augusta; W. V. Long, Savannah.  
 South Carolina: J. C. Metts, Savannah; Stewart D. Brown, Royston; J. M. Byne, Jr., Waynesboro.  
 Tennessee: J. T. McCall, Rome; Trammell Starr, Dalton; F. H. Simonton, Chickamauga.

MEDICAL ASSOCIATION OF GEORGIA  
DIRECTORY

On the following pages of this Journal will be found the directory of the Medical Association of Georgia for 1946.

Much effort has been expended in compiling this directory, for the reason the Association is in a post-war reorganization period. During the recent war more than 600 of our members left their homes to serve with the armed forces. Most of them have returned home, but some have found new locations. Members' names must be reported to the Association's secretary by their respective county medical societies. If for any reason you do not find your name included in the directory, you should consult the officers of your county medical society. If your name was listed incorrectly, please notify this Journal.



# MEDICAL ASSOCIATION OF GEORGIA

## Members (alphabetically) 1946

### A

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 Aldrich, Fred N., Persons Bldg., Macon  
 Alexander, G. H., Forsyth  
 Alford, A. E. B., Bainbridge  
 Allen, C. H., Bremen  
 Allen, Eustace A., Medical Arts Bldg., Atlanta  
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 Allen, H. D., Jr., Milledgeville  
 Allen, H. Homer, Decatur Bank & Trust Co. Bldg., Decatur  
 Allen, L. C., Hoschton  
 Allen, Lane H., Medical College, Augusta  
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 Anderson, M. W., Social Circle  
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 Anderson, S. A., Milledgeville  
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 Banks, G. T., Fair Mount  
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 Barger, E. A., Waynesboro  
 Barger, T. F., Perkins (Hon.)  
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 Collins, Katherine R., Turnerville  
 (Hon.)  
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 (Asso.)  
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 Atlanta  
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 Columbus (Hon.)  
 Cooper, Chas. F., Persons Bldg.,  
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 Cooper, Frederick W., Jr., Emory  
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 University  
 Cooper, J. J., Cedartown  
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 Corry, J. A., Barnesville  
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## D

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 Davis, E. B., Byromville  
 Davis, E. S., Acworth  
 Davis, Floyd, Ware County Hospital, Waycross (Asso.)

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 DeCaradeuc, St. J. R., DeRenne Apts., Savannah  
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 Dellinger, Raiden W., Rome  
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 Dillard, J. B., Davisboro (Hon.)  
 Dillinger, Geo. R., Thomasville  
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 Dover, Tom A., Athens  
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 Elliott, C. C., Sargent  
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 Elliott, W. G., Cuthbert  
 Ellis, H. C., McDonough  
 Ellis, J. W., Kennesaw  
 Ellis, S. B., Pitts  
 Ellis, W. P., Chipley  
 Elmore, B. V., Rome  
 English, R. E. L., Griffin  
 Enzor, R. H., Smithville  
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Ferrell, T. J., Waycross  
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Flanagan, W. M., Waycross  
Fleming, A., Folkston  
Fleming, Carlton A., Tifton  
Fletcher, Elizabeth, Statesboro  
Florence, Loree, Athens  
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tist Hospital, Atlanta (Asso.)  
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Fountain, J. A., Persons Bldg.,  
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Frye, A. H., Griffin  
Frye, Augustus H., Jr., Griffin  
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Garrett, J. A., Meigs  
Garrett, Luke G., Austell  
Garrett, Luke G., Jr., Austell  
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Giddens, I. S., Adel  
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Gilbert, Warren M., Rome  
Gilbert, W. L., Georgian Terrace  
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Good, W. H., Jr., Toccoa  
Goodman, Leon J., First National  
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Goodpasture, W. C., Medical Arts  
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 Hyden, Wm. U., Trion  
 Hydrick, Peter, College Park

## I

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 Jackson, J. H., Barnesville  
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 Waycross (Asso.)  
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 Johnson, J. E., Jr., Elberton  
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 Jolley, J. S., Homer  
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Lee, H. G., Millen  
Lee, Lawrence, DeRenne Apts.,  
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Lewis, W. H., Siloam  
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Little, G. H., Trion  
Little, R. N., Summerville  
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- Moore, Clifford, Lindale
- Moore, Ed. L., Statesboro
- Moore, Haywood L., Brunswick
- Moore, Lewis Wm., Georgia Baptist Hospital, Atlanta (Asso.)
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Parker, G. M., Carnesville  
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Parkerson, S. T., McRae  
Parks, Harry, Candler Bldg., Atlanta  
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Patton, L. S., Athens  
Patton, Samuel E., Persons Bldg.,  
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 Rogers, O. L., Sandersville  
 Rogers, R. L., Gainesville  
 Rogers, T. E., 120 Clishy Place, Macon  
 Roles, C. L., Camilla  
 Rollins, J. C., Dalton  
 Roper, C. J., Jasper  
 Roper, E. A., Jasper  
 Rosen, E. A., Dalton  
 Rosen, E. F., 5 E. Gordon St., Savannah  
 Rosen, Samuel F., 4 E. Jones St., Savannah  
 Rosenherg, H. J., 478 Peachtree St., N.E., Atlanta  
 Ross, Grace R., Cedartown  
 Ross, Thos. L., Jr., 700 Spring St., Macon  
 Rouglin, L. C., First Natl. Bank Bldg., Atlanta  
 Roule, J. Victor, Southern Finance Bldg., Augusta  
 Routledge, A. F., Rome  
 Rozar, A. R., Persons Bldg., Macon  
 Rubin, Jacob, 350 Bull St., Savannah  
 Rubin, Samuel N., Gordon  
 Rudder, Fred F., Grand Theatre Bldg., Atlanta  
 Rupp, Alice, 1201 S. Main St., Jacksonville, Fla.  
 Rushin, Chas. E., 478 Peachtree St., N.E., Atlanta
- S
- Sage, Dan Y., Medical Arts Bldg., Atlanta  
 St. John, Jas. O., Newnan  
 Sams, F. H., Reynolds  
 Sams, Henry L., Dalton  
 Sams, J. R., Covington  
 Sanchez, A. S., 84 Marietta St., Atlanta  
 Sanchez, S. E., Barwick (Deceased)  
 Sanchez, S. E., Jr., Barwick  
 Sanders, A. S., 118 Forrest Ave., N.E., Atlanta  
 Sanders, Floyd R., Jr., Masonic Temple, Decatur  
 Sanderson, E. S., Medical College, Augusta  
 Sandison, J. Calvin, 478 Peachtree St., N.E., Atlanta  
 Sanford, Dudley Phelps, Southern Finance Bldg., Augusta  
 Sapp, C. J., Rome  
 Sappington, T. A., Thomaston  
 Sauls, H. C., Medical Arts Bldg., Atlanta  
 Saunders, A. F., Valdosta  
 Saurez, Annette McD., Cuthbert (Hon.)  
 Savage, C. P., Montezuma  
 Saxton, Alton J., Veterans Administration, Atlanta (Asso.)  
 Scales, S. F., Carrollton  
 Scarborough, J. E., Emory University Hospital, Emory University  
 Schaefer, W. Bruce, Toccoa  
 Scharnitzky, E. O., 1262 Greene St., Augusta  
 Scheinbaum, C. N., Candler Bldg., Atlanta  
 Schenck, H. C., Georgia Dept. of Public Health, Atlanta  
 Schimmel, W. A., Unadilla  
 Schley, Frank B., 303 11th St., Columbus  
 Schmidt, Henry L., Medical College, Augusta  
 Schneider, J. F., First Natl. Bank Bldg., Atlanta  
 Schneider, M. M., 12½ W. Taylor St., Savannah  
 Schneider, W. J., Folkston  
 Schroder, J. Spalding, Medical Arts Bldg., Atlanta  
 Schuessler, George, 1437 2nd Ave., Columbus  
 Schwall, Edward W., Gracewood  
 Scofield, I. F., Canton  
 Scott, Wilbert E., Jr., Emory University Hospital, Emory University (Asso.)  
 Sealey, Romero M., Georgia Baptist Hospital, Atlanta (Asso.)  
 Seaman, Henry A., Waycross  
 Sellers, T. F., Georgia Dept. of Public Health, Atlanta  
 Selman, W. A., 157 Forrest Ave., N.E., Atlanta  
 Sewell, W. A., Rome  
 Seymour, Glenn E., Albany  
 Shackelford, B. L., Medical Arts Bldg., Atlanta  
 Shanks, Edgar D., 478 Peachtree St., N.E., Atlanta  
 Shanks, Edgar D., Jr., University Hospital, Augusta  
 Sharp, C. K., Arlington  
 Sharp, C. M., Florida  
 Sharpe, W. W., III, Alma  
 Sharpley, Helen, 109 E. Jones St., Savannah  
 Sharpley, H. F., Jr., DeRenne Apts., Savannah  
 Sharpley, John G., DeRenne Apts., Savannah  
 Shaw, L. W., 124 E. Oglethorpe Ave., Savannah  
 Shaw, M. F., Omega  
 Shearouse, J. Wm., 14 E. Taylor St., Savannah  
 Shellhouse, L. H., Willacoochee

- Sheldon, Walter H., Grady Hospital, Atlanta  
 Shepard, Kirk, Thomasville  
 Shepard, J. L., Damascus  
 Shepard, Richard C., LaFayette  
 Shepard, V. Duncan, 864 Juniper St., N.E., Atlanta  
 Shepard, W. O., Bluffton  
 Sherman, John H., University Hospital, Augusta  
 Shields, H. F., Chickamauga  
 Shinall, Robert P., Jr., Piedmont Hospital, Atlanta (Asso.)  
 Seigel, Alvin E., Medical Arts Bldg., Macon  
 Sikes, Walter A., Milledgeville  
 Sikes, Z. S., Milledgeville  
 Silver, D. M., Southern Finance Bldg., Augusta  
 Simmons, James O., Woodbine  
 Simmons, J. W., Brunswick  
 Simmons, W. E., Metter  
 Simmons, William G., Sylvania  
 Simonton, Fred H., Chickamauga  
 Simpson, A. W., Washington  
 Simpson, A. W., Jr., Washington  
 Simpson, John A., Athens  
 Sims, A. R., Richland  
 Sims, Marshall R., 157 Forrest Ave., N.E., Atlanta  
 Sinkoe, S. J., Candler Bldg., Atlanta  
 Skobba, Jos. Stanley, 478 Peachtree St., N.E., Atlanta  
 Sloan, W. P., Candler Bldg., Atlanta  
 Slocumb, C. B., Doerun  
 Snaha, T. G., Griffin  
 Smisson, Roy C., Fort Valley  
 Smith, Archibald, First Natl. Bank Bldg., Atlanta  
 Smith, A. C., Elberton  
 Smith, A. L., Cochran  
 Smith, B. T., Carnesville  
 Smith, Carter, Medical Arts Bldg., Atlanta  
 Smith, Chas. R., 1236 Broadway, Columbus  
 Smith, Charles W., 770 Cypress St., N.E., Atlanta  
 Smith, D. D., Swainsboro  
 Smith, E. J., Hahira  
 Smith, F. A., Elberton  
 Smith, G. B., Rome  
 Smith, Herschel A., Americus  
 Smith, Horace D., 10519 Ohio Ave., Los Angeles 25, Calif.  
 Smith, H. M., 9 W. Gordon St., Savannah  
 Smith, Inman, Rome  
 Smith, J. Allen, 700 Spring St., Macon  
 Smith, John E., Fitzgerald  
 Smith, J. Gregg, 22 W. Gaston St., Savannah  
 Smith, J. M., Cochran  
 Smith, J. R., Hahira  
 Smith, Leo, Waycross  
 Smith, L. A., Quitman  
 Smith, Linton, 427½ Moreland Ave., N.E., Atlanta  
 Smith, M. E., Milledgeville  
 Smith, M. F., 918 Bankhead Highway, N.W., Atlanta  
 Smith, P. H., 3 E. Gordon St., Savannah  
 Smith, Ralph B., 1700 N. Decatur Rd., N.E., Atlanta (Asso.)  
 Smith, R. H., Lincolnton  
 Smith, Richard L., Cochran  
 Smith, T. H., Valdosta  
 Smith, W. A., Medical Arts Bldg., Atlanta  
 Smith, W. J., Forsyth  
 Smith, W. P., Bowdon  
 Smith, W. P., Jr., 319 Church St., Decatur  
 Smith, W. Randolph, 478 Peachtree St., N.E., Atlanta  
 Snelling, W. R., 1315 4th Ave., Columbus  
 Spanjer, Raymond F., Cedartown  
 Spier, Eugene, Piedmont Hospital, Atlanta (Asso.)  
 Spikes, J. L., Doctors Bldg., Columbus  
 Spooner, John I., Donalsonville (Hon.)  
 Spruell, T. M., Temple (Hon.)  
 Stampa, Samuel, Candler Bldg., Atlanta  
 Standifer, J. G., Blakely  
 Stanford, J. W., Cartersville  
 Stapleton, C. E., Statesboro  
 Stapleton, J. L., 1130 5th Ave., Columbus  
 Starr, Trammell, Dalton  
 Stead, Eugene A., Jr., 50 Armstrong St., S.E., Atlanta  
 Steed, J. H., Dalton  
 Stegall, Robert E., U. S. Army  
 Stelling, Henry Geo., 3076½ Roswell Rd., N.E., Atlanta  
 Stephens, Amos Leslie, Jr., 478 Peachtree St., N.E., Atlanta  
 Stephens, R. G., Washington  
 Stephenson, C. W., Ringgold  
 Stevenson, C. A., Camilla  
 Stewart, Calvin B., 478 Peachtree St., N.E., Atlanta  
 Stewart, Jas. A., Portal  
 Stewart, J. Benham, 2nd Unit 57 Field Hospital, APO 65, c/o Postmaster, New York, N. Y.  
 Stewart, John S., Emory University Hospital, Emory University (Asso.)  
 Stewart, Phillip R., Monroe  
 Stillwell, J. D., Waycross  
 Stone, Chas. F., Jr., Medical Arts Bldg., Atlanta  
 Stoner, Cyrus H., Candler Bldg., Atlanta  
 Stoner, W. P., Waycross  
 Storey, W. E., 1312 3rd Ave., Columbus  
 Story, W. L., Ashburn  
 Stovall, J. T., Jefferson  
 Strickland, L. V., Cobbtown  
 Strickler, C. W., 123 Forrest Ave., N.E., Atlanta  
 Strickler, C. W., Jr., 123 Forrest Ave., N.E., Atlanta  
 Stuckey, Ann, Griffin  
 Stukes, J. T., Americus  
 Stump, Robert L., Jr., Valdosta  
 Styles, O. R., Cedartown  
 Suarez, Raymond, Medical Arts Bldg., Macon  
 Sumner, G. S., Sylvester  
 Swain, Bruce, Clarkesville  
 Swanson, Cosby, 478 Peachtree St., N.E., Atlanta  
 Swanson, Homer S., Medical Arts Bldg., Atlanta  
 Swilling, Evelyn, 553 Walnut St., Macon  
 Sydenstricker, V. P., University Hospital, Augusta
- T**
- Talmadge, Harry E., Athens  
 Talmadge, Sam M., Athens  
 Tanner, W. H., Route 2, Newnan  
 Taranto, Morris B., Mortgage Guarantee Bldg., Atlanta  
 Tarplee, Scott L., Grand Theatre Bldg., Atlanta  
 Tatum, P. A., Flowers Bldg., Columbus  
 Taylor, Lloyd B., 601 Whitaker St., Savannah  
 Taylor, R. L., Davisboro  
 Taylor, T. B., Douglasville  
 Teasley, B. C., Hartwell  
 Teem, M. V. B., Marietta  
 Templeton, C. M., Southern Finance Bldg., Augusta  
 Terrell, J. H., Toccoa  
 Terry, D. B., Homerville  
 Tessier, Claude E., Masonic Bldg., Augusta  
 Thebaut, Ben Robert, Candler Bldg., Atlanta  
 Thomas, D. R., Southern Finance Bldg., Augusta  
 Thomas, F. H., Valdosta  
 Thomas, Jos. A., Valdosta  
 Thomas, N. R., Albany  
 Thomas, Russell B., Americus  
 Thomas, W. C., Brunswick  
 Thomason, C. Griggs, 106 N. East Point, East Point  
 Thomason, W. L., 157 Forrest Ave., N.E., Atlanta  
 Thomasson, W. E., Carrollton  
 Thompson, Cleveland, Millen  
 Thompson, D. N., Elberton  
 Thompson, D. O., Candler Bldg., Atlanta  
 Thompson, Ernest, Monroe  
 Thompson, E. F., Valdosta  
 Thompson, John B., Jr., Flowers Bldg., Columbus  
 Thompson, O. R., 700 Spring St., Macon  
 Thompson, W. C., 826 Penn Ave., N.E., Atlanta  
 Thomson, James L., Eastman  
 Thornton, Lawson, 478 Peachtree St., N.E., Atlanta  
 Thrash, J. A., 1310 Broadway, Columbus



Threatte, Bruce, 204 11th St.,  
Columbus  
Thurmond, A. G., 623 Greene St.,  
Augusta  
Thurmond, J. W., 407 7th St.,  
Augusta  
Thurston, John Allen, 5998 Peach-  
tree Rd., Atlanta (Asso.)  
Thwaite, Walter, Quitman  
Tidmore, Joseph C., Dawson  
Tidmore, T. L., Piedmont Hospital,  
Atlanta  
Tidwell, J. T., Doctors Bldg.,  
Columbus  
Tillery, Bert, Swift Bldg., Columbus  
Timmons, C. C., 415 Milledge Rd.,  
Augusta  
Titshaw, H. S., Gainesville  
Todd, L. N., University Hospital,  
Augusta  
Tootle, G. W., Glennville  
Torpin, Richard, Medical College,  
Augusta  
Touchton, G. L., 114 E. Jones St.,  
Savannah  
Towson, Ira G., Box 145, Sea Island  
Train, J. K., 1107 Bull St.,  
Savannah  
Travis, W. D., Covington  
Traylor, James B., Social Circle  
Traylor, S. B., Barnesville  
Treusch, H. L., 2140 Peachtree Rd.,  
Atlanta  
Tribble, J. M., Senoia  
Trimble, W. H., 478 Peachtree St.,  
N.E., Atlanta  
Trincher, Irvin H., Emory University  
Hospital, Emory University  
(Asso.)  
Tucker, John P., Bainbridge  
Turk, L. N., Jr., Candler Bldg.,  
Atlanta  
Turner, J. D., Nashville  
Turner, John W., 151 Ponce de  
Leon Ave., N.E., Atlanta  
Turner, W. J., Ashburn (Deceased)  
Turner, W. W., Nashville  
Tye, J. P., Albany  
Tyre, J. Lawton, Screven

## U

Upchurch, W. E., Medical Arts Bldg.,  
Atlanta  
Upshaw, C. B., 18 4th St., N.W.,  
Atlanta  
Upson, E. T., 201 E. Hall St.,  
Savannah  
Usher, Chas., 6 E. Liberty St.,  
Savannah

## V

Valentine, Herbert E., Jr., Emory  
University Hospital, Emory  
University (Asso.)  
Van Buren, E., 768 Juniper St.,  
N.E., Atlanta  
Van Dyke, A. H., Grant Bldg.,  
Atlanta  
Vansant, C. V., Douglasville  
Vansant, T. J., Woodstock

Varner, John B., Medical Arts  
Bldg., Atlanta  
Vassey, G. C., Rossville  
Veale, Emory O., Arnoldsville  
Veatch, Jesse Wm., Jr., 490 Peach-  
tree St., N.E., Atlanta  
Velkoff, Abraham S., 26 Linden  
Ave., N.E., Atlanta  
Vella, Paul D., St. Joseph's  
Infirmary, Atlanta (Asso.)  
Venable, D. R., City Hospital,  
Columbus  
Venable, John H., Emory University  
Vermilye, John H., Box 34, Flagler  
Beach, Fla.  
Vickers, T. E., Harrison (Hon.)  
Vinson, C. D., 72 Anniston Ave., S.E.,  
Atlanta  
Vinson, T. O., Griffin  
Vinton, Luther M., 478 Peachtree St.,  
N.E., Atlanta  
Vogt, Elkin, Lithonia  
Volpitto, Perry P., University  
Hospital, Augusta

## W

Wahl, Ernest F., Thomasville  
Waites, S. L., Covington  
Walker, D. D., 700 Spring St.,  
Macon  
Walker, Exum B., 864 Juniper St.,  
N.E., Atlanta  
Walker, E. Y., Milledgeville  
Walker, Geo. L., Griffin  
Walker, J. L., Bowdon  
Walker, Jno. R., 922 W. Peachtree  
St., N.W., Atlanta  
Walker, W. A., Cairo (Hon.)  
Wall, C. K., Thomasville  
Wall, W. H., Blakely  
Wallace, J. W., Douglas  
Waller, C. P., Milledgeville  
Wallis, J. R., Lovejoy  
Walter, R. D., Calhoun  
Walton, John M., 418 Capitol Ave.,  
S.E., Atlanta  
Ward, C. D., 1345 Greene St.,  
Augusta  
Ward, Chas. S., 478 Peachtree St.,  
N.E., Atlanta  
Ward, Eugene L., Gainesville  
Ward, Francis O., Fitzgerald  
Ward, G. A., Elberton  
Ward, J. W., Baconton (Hon.)  
Ware, A. D., Toombsboro  
Ware, D. B., Fitzgerald  
Ware, Ford, Bankers Ins. Bldg.,  
Macon  
Ware, F. L., Warrenton  
Waring, A. J., DeRenne Apts.,  
Savannah  
Warnell, J. B., Cairo  
Warner, Wm. Philip, Jr., 478 Peach-  
tree St., N.E., Atlanta  
Warnock, C. Murray, 478 Peachtree  
St., N.E., Atlanta  
Warren, W. C., Jr., 478 Peachtree  
St., N.E., Atlanta  
Wasden, C. N., Bankers Ins. Bldg.,  
Macon  
Wasden, Harry A., Quitman

Waters, Wm. C., Jr., 762 Cypress St.,  
N.E., Atlanta  
Watkins, E. C., Brooklet  
Watkins, Ed W., Ellijay  
Watson, Edwin R., 553 Walnut St.,  
Macon  
Watson, O. O., Persons Bldg.,  
Macon  
Watt, C. H., Thomasville  
Watts, J. W., Bowdon  
Waugh, William, Nashville  
Weaver, H. G., 700 Spring St.,  
Macon  
Weaver, J. C., 78 Ellis St., N.E.,  
Atlanta (Hon.)  
Weaver, O. H., 700 Spring St.,  
Macon  
Webb, M. L., Tifton  
Weeks, J. L., Harlem  
Weeks, R. B., Southern Finance  
Bldg., Augusta  
Weens, H. S., Grady Hospital,  
Atlanta  
Weinberg, Jas. I., 762 Cypress St.,  
N.E., Atlanta  
Weinstein, A. A., 126 Forrest Ave.,  
N.E., Atlanta  
Weitz, Frank, Medical Arts Bldg.,  
Atlanta  
Welch, Carl B., Attapulugus  
Welch, L. L., Marietta  
Wells, W. Frank, Medical Arts  
Bldg., Atlanta  
West, C. M., Candler Bldg., Atlanta  
West, E. M., University Hospital,  
Augusta  
Westbrook, R. J., Ila (Hon.)  
Wheat, R. F., Bainbridge  
Whelan, E. J., 14 W. Jones St.,  
Savannah  
Whelchel, A. J., Cordele  
Whelchel, C. D., Gainesville  
Whelchel, F. C., Alto  
Whelchel, G. O., Athens  
Whipple, R. L., Cochran  
Whipple, Robert L., Jr., Medical  
Arts Bldg., Atlanta  
White, Geo. M., Rockmart  
White, J. Bruce, 820 Temple Ave.,  
Knoxville, Tenn.  
White, Jas. R., 478 Peachtree St.,  
N.E., Atlanta  
Whitely, Seals L., Cedartown  
(Deceased)  
Whitehead, C. Mark, LaGrange  
Whiteside, J. H., Statesboro  
Whitfield, Truman, Dalton  
Whitley, Jas. R., Dalton  
Whitley, L. L., Athens  
Whitman, O. F., Albany  
Whittle, Wm. E., Iron City  
Whitworth, C. W., Gainesville  
Wilcox, E. A., 1345 Greene St.,  
Augusta  
Wiley, John D., Sparta  
Wilkes, W. A., University Hospital,  
Augusta  
Wilkinson, W. L., Bainbridge  
Willcox, W. D., Fitzgerald

Williams, A. F., 127 E. Gordon St., Savannah	Wilson, J. M., Doctors Bldg., Columbus	Woodall, J. B., Moultrie
Williams, Caroline Jane, 768 Juniper St., N.E., Atlanta	Wilson, L. E., Bowdon	Woodroof, Wm. L., Newnan
Williams, Chas. Roy, Wadley	Wilson, Pleas, Newborn	Woods, O. C., Milledgeville
Williams, David C., 216 Sycamore Dr., Decatur	Wilson, Richard, 864 Juniper St., N.E., Atlanta	Woolridge, J. C., Murrah Bldg., Columbus
Williams, David C., Jr., Healey Bldg., Atlanta	Wilson, S. E., 408 S.E. 17th Ave., Ft. Lauderdale, Fla.	Woolley, Lawrence F., 768 Juniper St., N.E., Atlanta
Williams, Geo. A., Medical Arts Bldg., Atlanta	Wilson, W. D., 315 Abercorn St., Savannah	Wooten, L. O., Cordele
Williams, H. J., Cordele	Winchester, M. E., Brunswick	Word, J. J., Blue Ridge
Williams, L. E., Cordele	Winn, J. H., Swift Bldg., Columbus	Work, S. D., Jr., Forsyth
Williams, L. W., 105 E. Jones St., Savannah	Winstead, Geo. A., St. Joseph's Infirmary, Atlanta (Asso.)	Worthy, W. Steve, Carrollton
Williams, M. W., Camilla	Wise, B. J., Americus (Hon.)	Wright, E. S., Medical Arts Bldg., Atlanta
Williams, Norton L., Rome	Witmer, C. A., Waycross	Wright, Geo. W., Southern Finance Bldg., Augusta
Williams, P. L., Cordele	Wofford, W. E., Cartersville	Wright, J. J. C., Route 1, Rockmart
Williams, T. C., Valdosta	Wolfe, David M., Albany	Wright, P. B., 1345 Greene St., Augusta
Williams, W. A., 700 Spring St., Macon	Wolff, Bernard P., Medical Arts Bldg., Atlanta	
Williams, W. J., Southern Finance Bldg., Augusta	Wolff, Luther H., 1312 3rd Ave., Columbus	<b>Y</b>
Williamson, J. S., Trion	Woodbury, Robert A., Medical College, Augusta	Yampolsky, Joseph 478 Peachtree St., N.E., Atlanta
Williamson, Milton W., 106 N. East Point, East Point	Wood, D. Lloyd, Dalton	Yarbrough, Y. H., Milledgeville
Willingham, T. I., 56 5th St., N.E., Atlanta	Wood, James A., 214 Vineville Ave., Macon	Yeomans, James W., Jesup
Willis, C. H., Southern Finance Bldg., Atlanta	Wood, Jay G., U. S. Veterans Hospital, Atlanta	York, Jesse H., Medical Arts Bldg., Atlanta
Willis, G. W., Ocilla	Wood, Kenneth, Leslie	Youmans, C. R., Hazlehurst
Willis, J. N., Swift Bldg., Columbus	Wood, O. S., Washington	Youmans, J. R., Doctors Bldg., Columbus
Willis, L. W., Bainbridge	Wood, R. Hugh, Emory University Hospital, Emory University	Youmans, S. S., Swainsboro
Willis, Tom Vann, Brunswick	Woodall, Frank M., Thomaston	Young, S. E., Midland (Hon.)
Wills, C. E., Washington	Woodall, James A., Thomaston	<b>Z</b>

(Continued on Page 397)

## NEWS ITEMS

Dr. Jack L. Austin, Griffin, recently released from active duty with the United States Army after more than four years' service, plans to open an office in Griffin January 1 for the treatment of eye, ear, nose and throat diseases.

\* \* \*

Dr. John L. Barner, Athens, announces his return from military service and opening of his practice in diagnostic and therapeutic radiology and oncology at the Athens General Hospital, Athens.

\* \* \*

Dr. Hilton J. Brown, formerly of Douglasville, a former physician in the U. S. Army Medical Corps, has opened offices for the practice of medicine at Folkston.

\* \* \*

Dr. R. Frank Cary, Macon, city-county health officer, recently announced the re-opening of health center clinics for both white and negroes. Suspended for the recent VD-TB survey, the re-opening had to be delayed until the offices and clinic rooms were cleared of survey equipment. Venereal clinics will be conducted daily.

\* \* \*

Dr. Fred N. Clements, Adel, recently discharged from military service after serving for more than two years, will be associated with his father, Dr. H. W. Clements, for the practice of medicine at Adel.

\* \* \*

Dr. Robert T. Kelley, chief of the Orthopedic Division, Emory University School of Medicine; Dr. Philip Warner, orthopedic surgeon of Atlanta, and Dr. R. L. Bennett, Warm Springs, who is also professor of physical medicine at Emory University School of Medicine, have been added to the staff of the Crippled Children's Division of the State Department of Welfare.

Dr. James H. Crawford and Dr. Pratt Cheek, Jr., Atlanta, announce their association for the practice of eye, ear, nose, and throat diseases, 616 Grant Building, Atlanta.

\* \* \*

Dr. John B. Duncan, Atlanta, announces that Dr. Paul E. Turrentine is now associated with him in the practice of obstetrics and gynecology, 306 Doctors Building, Atlanta.

\* \* \*

Dr. M. A. Ehrlich, Bainbridge, has been appointed Veterans' Administration physician for Decatur County. Dr. Ehrlich has served as local medical examiner since 1925. He is a veteran of World War I and has been active in American Legion work since the local post was organized in 1919.

\* \* \*

The Georgia Baptist Hospital staff dinner meeting was held in the dining room of the Nurses' Home, November 19. Dr. C. E. Rushin, secretary.

\* \* \*

Dr. Linton Gerdine, Athens, was recently appointed as assistant physician of the University of Georgia, Athens. Dr. Gerdine will assist Dr. H. I. Reynolds, University physician, in the Gilbert Memorial Infirmary and the Co-ordinate Infirmary.

\* \* \*

Dr. Milton M. Green, formerly with the Warren A. Candler Hospital, Savannah, has joined the medical staff at Scott Hospital, Milledgeville.

\* \* \*

Dr. Clair A. Henderson, Savannah, city and county health commissioner, recently received the Lucas Trophy for performing the most worthwhile accomplishment for Savannah in 1945; his work in the mass tuberculosis and venereal disease drive last fall.

(Continued on Page 413)



# MEDICAL ASSOCIATION OF GEORGIA

## COUNTY MEDICAL SOCIETIES 1946

### APPLING COUNTY

#### Officers

President.....Overstreet, E. J.  
 Secretary-Treasurer.....Holt, James T.  
 Delegate.....Holt, James T.

#### Members

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 Holt, James T., Baxley  
 Kennedy, F. D., Baxley  
 McCracken, H. C., Baxley  
 Overstreet, E. J., Baxley

### BALDWIN COUNTY

#### Officers

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 Vice-President.....Echols, G. L.  
 Secretary-Treasurer.....Combs, J. D.  
 Delegate.....Cox, C. G.  
 Alternate Delegate.....Fulghum, C. H.  
 Censors: Bradford, R. W.; Bostick,  
 W. A.; and Fulghum, C. B.

#### Members

Allen, E. W., Milledgeville  
 Allen, H. D., Jr., Milledgeville  
 Anderson, J. M., U. S. Public Health  
 Service, Lexington, Ky.  
 Anderson, S. A., Milledgeville  
 Baby, B. B., Jr., Battey State Hos-  
 pital, Rome  
 Bailey, L. A., Milledgeville  
 Binion, Richard, Milledgeville  
 Bostick, W. A., Milledgeville  
 Bradford, R. W., Milledgeville  
 Bradley, J. D., Duke University,  
 Durham, N. C.  
 Cary, H. R., Milledgeville  
 Clodfelter, Thos. C., Milledgeville  
 Combs, J. D., Milledgeville  
 Cox, C. G., Milledgeville  
 Echols, Geo. L., Milledgeville  
 Fernan-Nunez, M., Milledgeville  
 Fulghum, C. B., Milledgeville  
 Garrard, J. I., Milledgeville  
 Mays, J. R. S., Macon  
 Mitchell, Frank, Sr., Beverly Knoll  
 Sanitarium, Asheville, N. C.  
 Mitchell, Frank B., Jr., Milledgeville  
 New, J. S., University Hospital,  
 Augusta  
 Pennington, L. E., Milledgeville  
 Pennington, Veronica Murphy,  
 Milledgeville  
 Rupp, Alice, 1201 S. Main St.,  
 Jacksonville, Fla.  
 Sanchez, A. S., 84 Marietta St.,  
 Atlanta  
 Schwall, Edward W., Gracewood  
 Sikes, Walter A., Milledgeville  
 Sikes, Z. S., Milledgeville  
 Stewart, J. Benham, 2nd Unit 57  
 Field Hospital, APO 65,  
 c/o Postmaster, New York, N. Y.  
 Walker, E. Y., Milledgeville  
 Waller, C. P., Milledgeville  
 Woods, O. C., Milledgeville  
 Yarbrough, Y. H., Milledgeville

### BANKS COUNTY

#### Member

Jolley, J. S., Homer

### BARTOW COUNTY

#### Officers

President.....McGowan, H. S.  
 Vice-President.....Bradford, H. B.  
 Secretary-Treasurer.....Horton, A. L.  
 Delegate.....Bradford, H. B.  
 Censors: Wofford, W. E.; Quillian,  
 W. B.; and Bradford, H. B.

#### Members

Adair, R. E., Cartersville (Hon.)  
 Bradford, H. B., Cartersville  
 Burton, R. E. Kingston  
 Horton, A. L., Cartersville  
 Howell, S. M., Cartersville  
 McGowan, H. S., Cartersville  
 Quillian, W. B., Cartersville  
 Stanford, J. W., Cartersville  
 Wofford, W. E., Cartersville

### BEN HILL COUNTY

#### Officers

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 Vice-President.....Cornwell, G. K.  
 Secretary-Treas.....Ward, Francis O.  
 Delegate.....Willcox, W. D.  
 Alternate Delegate.....Smith, John E.  
 Censors: Ware, B. D.; Coffee, W. P.;  
 and Willis, G. W.

#### Members

Coffee, W. P., Fitzgerald  
 Cornwell, G. K., Fitzgerald  
 Dismuke, H. L., Ocilla  
 Harper, A., Wray  
 McMillan, J. E., Fitzgerald  
 Smith, John E., Fitzgerald  
 Ward, Francis O., Fitzgerald  
 Ware, D. B., Fitzgerald  
 Willcox, W. D., Fitzgerald  
 Willis, G. W., Ocilla

### BIBB COUNTY

#### Officers

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 President-Elect.....Wasden, C. N.  
 Vice-President.....McAllister, R. W.  
 Secretary-Treasurer.....Phillips, A. M.  
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 Delegate.....Kay, J. B.  
 Alt. Delegate.....Applewhite, J. D.  
 Alt. Delegate.....Atkinson, H. C.  
 Censors: Weaver, O. H.; Bazemore,  
 Wallace; and Richardson, C. H.,

#### Members

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 Macon  
 Anderson, J. C., Persons Bldg.,  
 Macon  
 Anderson, C. L., First Natl. Bank  
 Bldg., Macon  
 Applewhite, J. D., 700 Spring St.,  
 Macon  
 Atkinson, H. C., 700 Spring St.,  
 Macon  
 Barton, Wm. L., Persons Bldg.,  
 Macon  
 Bashinski, Ben, 700 Spring St.,  
 Macon  
 Baxley, W. W., Persons Bldg.,  
 Macon

Bazemore, Wallace, 553 Walnut St.,  
 Macon  
 Billingshurst, Geo. A., Persons Bldg.,  
 Macon  
 Blum, Leo J., Jr., Warner Robins  
 Boswell, W. Chas., Persons Bldg.,  
 Macon  
 Branan, Fred H., Medical Arts Bldg.,  
 Macon  
 Brown, Roland A., Medical Arts  
 Bldg., Macon  
 Carey, R. Frank, Board of Health,  
 Macon  
 Chrisman, W. W., Doctors Bldg.,  
 Macon  
 Clay, J. Emory, Clinic Hospital,  
 Macon  
 Cole, Allan A., Warner Robins  
 Cooper, Chas. F., Persons Bldg.,  
 Macon  
 Corn, Ernest, 700 Spring St., Macon  
 Dove, W. B., 135 Boulevard Ave.,  
 Macon  
 DuPree, Geo. W., Gordon  
 DuPree, John T., Gordon  
 Edenfield, Robert Watts, 700 Spring  
 St., Macon  
 Farmer, C. Hall, 553 Walnut St.,  
 Macon  
 Fountain, J. A., Persons Bldg.,  
 Macon  
 Gallemore, John L., Perry  
 Golsan, W. R., Persons Bldg., Macon  
 Goldstein, Josef J., Warner Robins  
 Goodman, Leon J., First Natl. Bank  
 Macon  
 Goolsby, R. Cullen, Jr., 700 Spring  
 St., Macon  
 Hall, J. I., Bankers Ins. Bldg.,  
 Macon  
 Hall, T. H., Grand Bldg., Macon  
 Harrold, C. C., 700 Spring St.,  
 Macon  
 Harrold, Thomas, 700 Spring St.,  
 Macon  
 Hatcher, Milford B., 700 Spring St.,  
 Macon  
 Holmes, J. P., Persons Bldg., Macon  
 Houser, F. M., Grand Bldg., Macon  
 Hurley, T. A., Clinic Hospital,  
 Macon  
 James, L. P., 700 Spring St., Macon  
 Jarratt, W. D., 553 Walnut St.,  
 Macon  
 Johnson, Geo. L., Veterans Admin.  
 Hospital, Tuscaloosa, Ala.  
 Johnson, J. E. L., Roberta  
 Jordan, Wm. K., 700 Spring St.,  
 Macon  
 Kay, J. B., Byron  
 Keen, O. F., Persons Bldg., Macon  
 King, J. L., Persons Bldg., Macon  
 Mass, Max, Macon Hospital, Macon  
 Massenburg, G. Y., Clinic Hospital,  
 Macon  
 McAfee, L. C., 618 Forsyth St.,  
 Macon

McAllister, R. W., 700 Spring St.,  
Macon  
McLaughlin, C. K., Bankers Ins.  
Bldg., Macon  
McMichael, V. H., Clinic Hospital,  
Macon  
Meriwether, W. W., Persons Bldg.,  
Macon  
Mobley, W. E., 563 College St.,  
Macon  
Nathan, Daniel E., Fort Valley  
Neuberg, S. Charlotte, 700 Spring  
St., Macon  
Newman, W. A., 700 Spring St.,  
Macon  
Newton, R. G., Persons Bldg.,  
Macon  
Patton, Samuel E., Persons Bldg.,  
Macon  
Penington, C. L., Nottingham Drive,  
Macon  
Phillips, A. M., Bankers Ins. Bldg.,  
Macon  
Pope, Edgar M., 700 Spring St.,  
Macon  
Porch, Leon D., 700 Spring St.,  
Macon  
Prescott, Eustace H., Bibb County  
Health Center, Macon  
Rawls, Lewis L., Persons Bldg.,  
Macon  
Reifler, R. M., First Natl. Bank  
Bldg., Macon  
Richardson, C. H., 700 Spring St.,  
Macon  
Richardson, C. H., Jr., 700 Spring  
St., Macon  
Richardson, R. W., Persons Bldg.,  
Macon  
Ridley, C. L., Macon Hospital,  
Macon  
Rogers, T. E., 120 Clisby Place,  
Macon  
Ross, Thos. L., Jr., 700 Spring St.,  
Macon  
Rozar, A. R., Persons Bldg., Macon  
Ruben, Samuel N., Gordon  
Siegel, Alvin E., Medical Arts Bldg.,  
Macon  
Smisson, Roy C., Fort Valley  
Smith, Horace D., 10519 Ohio Ave.,  
Los Angeles 25, Calif.  
Smith, J. Allen, 700 Spring St.,  
Macon  
Suarez, Raymond, Medical Arts  
Bldg., Macon  
Swilling, Evelyn, Medical Arts Bldg.,  
Macon  
Thompson, O. R., 700 Spring St.,  
Macon  
Walker, D. D., 700 Spring St.,  
Macon  
Ware, Ford, Bankers Ins. Bldg.,  
Macon  
Wasden, C. N., Bankers Ins., Bldg.,  
Macon  
Watson, Edwin R., 553 Walnut St.,  
Macon  
Watson, O. O., Persons Bldg., Macon

Weaver, H. G., 700 Spring St.,  
Macon  
Weaver, Olin H., 700 Spring St.,  
Macon  
Williams, W. A., 700 Spring St.,  
Macon  
Wood, James A., 214 Vineville Ave.,  
Macon  
Zackery, J. D., Gray

### BLUE RIDGE SOCIETY

#### Officers

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Vice-President.....Chastain, W. C.  
Secretary-Treasurer.....Watkins, Ed W.

#### Members

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Chastain, W. C., Ellijay  
Edge, H. M., Blairsville  
Hicks, Thomas J., McCaysville  
O'Daniel, James F., Ellijay  
O'Daniel, John Y., Ellijay  
Shanks, Edgar D., Jr., University  
Hospital, Augusta  
Watkins, Ed W., Ellijay  
West, E. M., University Hospital,  
Augusta  
Word, J. J., Blue Ridge

### BROOKS COUNTY

#### Officers

President.....Jones, A. B., Jr.  
Vice-President.....Smith, L. A.  
Secretary-Treas.....Wasden, Harry A.  
Delegate.....Smith, L. A.  
Alternate Delegate.....Jones, A. B., Jr.

#### Members

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Smith, L. A., Quitman  
Thwaite, Walter, Quitman  
Wasden, Harry A., Quitman

### BULLOCH-CANDLER-EVANS COUNTIES

#### Officers

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Vice-President.....Fletcher, Elizabeth  
Secretary-Treasurer.....Griffin, L. H.  
Delegate.....Daniel, A. B.  
Alternate Delegate.....Kennedy, R. L.  
Censors: Floyd, W. E.; Daniel, J.  
W.; and Simmons, W. E.

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Daniel, J. W., Claxton  
Deal, B. A., Statesboro  
Fletcher, Elizabeth, Statesboro  
Floyd, W. E., Statesboro  
Griffin, Louie H., Claxton  
Kennedy, R. L., Metter  
Loranger, James C., Claxton  
McElveen, J. M., Brooklet  
Mooney, A. J., Statesboro (Deceased)  
Mooney, John, Jr., Statesboro  
Moore, Ed L., Statesboro  
Nevil, J. L., Metter  
Olliff, H. H., Register  
Simmons, W. E., Metter  
Stapleton, C. E., Statesboro  
Stewart, Jas. A., Portal  
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### BURKE COUNTY

#### Officers

#### Members

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Vice-President.....McCarver, W. C.  
Secretary-Treas.....Lundquist, W. D.  
Delegate.....Byne, J. M., Jr.  
Alternate Delegate.....Lowe, W. R.

#### Members

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Bent, H. F., Midville  
Butterfield, Donald L., Waynesboro  
Byne, J. M., Jr., Waynesboro  
Hillis, W. W., Sardis  
Lowe, W. R., Midville  
Lundquist, W. D., Waynesboro  
McCarver, W. C., Vidette

### CARROLL COUNTY

#### Officers

President.....Worthy, W. Steve  
Vice-President.....Berry, R. L.  
Secretary-Treasurer.....Barker, H. L.  
Delegate.....Scales, S. F.  
Alternate Delegate.....Reese, D. S.

#### Members

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Barker, H. L., Carrollton  
Berry, R. L., Villa Rica  
Denny, Roy L., Carrollton  
Hogue, W. L., Villa Rica  
Holtz, Louis, Carrollton  
Nutt, J. J., Bowdon  
Powell, B. C., Villa Rica  
Powell, John E., Villa Rica  
Reese, D. S., Carrollton  
Roberts, L. J., Carrollton  
Roberts, O. W., Carrollton  
Robertson, J. G., Jr., City Hospital,  
Winston-Salem, N. C.

Scales, S. F., Carrollton  
Smith, W. P., Bowdon  
Spruell, T. M., Temple (Hon.)  
Thomasson, W. E., Carrollton  
Walker, J. L., Bowdon  
Watts, J. W., Bowdon  
Wilson, L. E., Bowdon  
Worthy, W. Steve, Carrollton

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Vice-President.....Porter, J. E.  
Secy.-Treasurer.....Johnson, G. H., Jr.  
Delegate.....Elliott, J. L.  
Delegate.....Touchton, G. L.  
Censors: Broderick, J. R.; Whelan,  
E. J.; and Touchton, G. L.

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Savannah  
Bedingfield, W. O., 612 Drayton St.,  
Savannah  
Bowden, Ralph H., 24 W. Gaston St.,  
Savannah  
Broderick, J. R., 415 Abercorn St.,  
Savannah  
Brown, C. T., Guyton  
Brown, F. B., 612 Drayton St.,  
Savannah  
Brown, Walter E., 14 W. Hull St.,  
Savannah



Charlton, T. J., 220 E. Oglethorpe Ave., Savannah  
 Chisholm, J. F., 512 Abercorn St., Savannah  
 Cole, W. A., 32 E. Taylor St., Savannah  
 Crawford, W. B., Jr., 14 E. Taylor St., Savannah  
 Crawford, W. B., Sr., 14 E. Taylor St., Savannah  
 Dancy, W. R., 102 W. Jones St., Savannah  
 Daniel, J. W., 5 E. Jones St., Savannah  
 Daniel Jno. W., Jr., 5 E. Jones St., Savannah  
 Davis, Claude L., Hinesville  
 DeCaradeuc, St. J. R., DeRenne Apts., Savannah  
 Demmond, E. C., DeRenne Apts., Savannah  
 Drane, Robert, DeRenne Apts., Savannah  
 Dunn, L. B., 114 E. Gaston St., Savannah  
 Edwards, D. B., 606 Drayton St., Savannah  
 Egan, M. J., 210 E. Liberty St., Savannah  
 Elliott, J. L., 212 E. Huntingdon St., Savannah  
 Epting, M. J., 12 W. Jones St., Savannah  
 Exley, H. T., 116 E. Jones St., Savannah  
 Faggart, G. H., 18 W. Oglethorpe Ave., Savannah  
 Fillingim, D. B., 118 E. Jones St., Savannah  
 Frech, Henry C., Jr., 423 Bull St., Savannah  
 Freedman, L. M., 101½ E. Gordon St., Savannah  
 Gleaton, E. N., 2 E. Jones St., Savannah  
 Graham, R. E., 212 E. Gaston St., Savannah  
 Ham, Oscar E., 12 W. Jones St., Savannah  
 Henderson, C. A., Health Center, Savannah  
 Holton, C. F., DeRenne Apts., Savannah  
 Hopkins, Anne, 22 E. Jones St., Savannah  
 Howard, Lee, DeRenne Apts., Savannah  
 Howkins, J. S., 111 E. Jones St., Savannah  
 Iseman, E., 103 E. Jones St., Savannah  
 Johnson, G. H. Jr., 116 E. Oglethorpe Ave., Savannah  
 Jones, Jabez, 11 W. Gordon St., Savannah  
 Kandel, H. M., 432 Abercorn St., Savannah  
 Kanter, W. W., 345 Bull St., Savannah  
 Kelley, Albert J., 4 E. Taylor St., Savannah

King, Ruskin, 10 W. Taylor St., Savannah  
 Lang, G. H., 202 E. Liberty St., Savannah  
 Lange, S. A., 12 E. Taylor St., Savannah  
 Lawless, Thos F., 204 E. Liberty St., Savannah  
 Lee, Lawrence, DeRenne Apts., Savannah  
 Levington, H. L., 209 E. Gaston St., Savannah  
 Long, W. V., DeSoto Hotel, Savannah  
 Lott, Oscar H., 111 E. Jones St., Savannah  
 Lynn, S. C., 124 E. Jones St., Savannah  
 Maner, E. N., 4 W. Liberty St., Savannah  
 Martin, R. V., 10 W. Jones St., Savannah  
 Massoud, M. A., Pineora  
 McGee, H. H., 7 W. Gordon St., Savannah  
 Metts, Jas. C., 427 Bull St., Savannah  
 Morrison, Howard J., 444 Drayton St., Savannah  
 Neville, R. L., 11 W. Gordon St., Savannah  
 Norton, W. A., 105 E. Oglethorpe Ave., Savannah  
 Oliver, R. L., DeRenne Apts., Savannah  
 Olmstead, G. T., 20 E. Taylor St., Savannah  
 O'Neill, J. C., 202 E. Liberty St., Savannah  
 Osborne, E. S., 19 E. Jones St., Savannah  
 Osteen, W. L., 610 Anderson Ave., Savannah  
 Pacifici, Joseph, 415 Abercorn St., Savannah  
 Pinholster, J. H., 4 W. Liberty St., Savannah  
 Porter, J. E., 106 E. Jones St., Savannah  
 Portman, H. J., 9 E. Gordon St., Savannah  
 Quattlebaum, J. K., 24 W. Gaston St., Savannah  
 Rabhan, L. J., 314 E. Gaston St., Savannah  
 Redmond, C. G., 701 Whitaker St., Savannah  
 Redmond, C. R. A., 11 W. Jones St., Savannah  
 Righton, H. Y., 101 E. Waldburg St., Savannah  
 Rosen, E. F., 5 E. Gordon St., Savannah  
 Rosen, Samuel F., 4 E. Jones St., Savannah  
 Ruhen, Jacob, 350 Bull St., Savannah  
 Schneider, M. M., 12½ W. Taylor St., Savannah  
 Sharpley, Helen, 109 E. Jones St., Savannah  
 Sharpley, H. F., Jr., DeRenne Apts., Savannah

Sharpley, John G., DeRenne Apts., Savannah  
 Shaw, L. W., 124 E. Oglethorpe Ave., Savannah  
 Shearouse, J. Wm., 14 E. Taylor St., Savannah  
 Smith, H. M., 9 W. Gordon St., Savannah  
 Smith, J. Gregg, 22 W. Gaston St., Savannah  
 Smith, P. H., 3 E. Gordon St., Savannah  
 Taylor, Lloyd B., 601 Whitaker St., Savannah  
 Touchton, G. L., 114 E. Jones St., Savannah  
 Train, J. K., 1107 Bull St., Savannah  
 Upson, E. T., 201 E. Hall St., Savannah  
 Usher, Charles, 6 E. Liberty St., Savannah  
 Waring, A. J., DeRenne Apts., Savannah  
 Whelan, E. J., 14 W. Jones St., Savannah  
 Williams, A. F., 127 E. Gordon St., Savannah  
 Williams, L. W., 105 E. Jones St., Savannah  
 Wilson, S. E., 403 S. E. 17th Ave., Ft. Lauderdale, Fla.  
 Wilson, W. D., 315 Abercorn St., Savannah

#### CHATTOOGA COUNTY

##### Officers

President.....Williamson, J. S.  
 Vice-President.....Hyden, W. U.  
 Secretary-Treasurer.....Hair, W. B.  
 Delegate.....Williamson, J. S.

##### Members

Hair, W. B., Summerville  
 Hyden, W. U., Trion  
 Little, G. H., Trion  
 Little, R. N., Summerville  
 Williamson, J. S., Trion

#### CHEROKEE-PICKENS COUNTIES

##### Officers

President.....Pettit, J. T.  
 Vice-President.....Roper, E. A.  
 Secretary-Treas. Jones, Robt. T., III  
 Delegate.....Andrews, C. R., Jr.  
 Delegate.....Roper, C. J.  
 Alt. Delegate.....Lewis, John R., Jr.  
 Alt. Delegate.....Scofield, I. F.  
 Censors: Roper, C. J.; Hendrix, A. M.; Scofield, I. F.; Andrews, C. R., Jr.; and Vansant, T. J.

##### Members

Andrews, C. R., Jr., Canton  
 Brooke, Geo. C., Canton  
 Coker, Grady N., Canton  
 Hendrix, A. M., Canton  
 Hendrix, M. G., Ball Ground  
 Jones, Robert T., III, Canton  
 Lewis, John R., Jr., Canton  
 Moore, R. M., Waleska (Hon.)  
 Pettit, J. T., Canton  
 Roper, C. J., Jasper  
 Roper, E. A., Jasper

Seofield, I. F., Tate  
Vansant, T. J., Woodstock

### CLARKE-MADISON-OCONEE COUNTIES

#### Officers

President ..... Talmadge, Sam M.  
Vice-President ..... Thompson, D. N.  
Secretary-Treasurer Barner, John L.  
Delegate ..... Talmadge, Sam M.  
Alt. Delegate ..... Talmadge, Harry E.  
Censors: Patton, L. S., and Harris,  
H. B.

#### Members

Banister, H. G., Ila  
Barner, John L., Athens  
Bond, D. T., Danielsville  
Brown, W. W., Athens  
Bryant, C. H., Comer  
Cabaniss, W. H., Athens  
Dover, Tom A., Athens  
Florence, Loree, Athens  
Gallis, Anthony H., Athens  
Gerdine, Linton, Athens  
Gholston, W. D., Danielsville  
Goldsmith, Lauren H., Athens  
Goss, R. M., Athens (Deceased)  
Green, James A., Athens  
Harris, H. B., Athens  
Holliday, Henry C., Athens  
Hubert, M. A., Athens  
Hunnicut, J. A., Jr., Athens  
Moss, W. L., Athens  
Mullins, DeWitt F., Jr., Army Insti-  
tute of Pathology, Washington,  
D. C.

Neighbors, J. B., Jr., Athens  
Patton, L. S., Athens  
Reynolds, H. I., Athens  
Simpson, John A., Athens  
Talmadge, Harry E., Athens  
Talmadge, Sam M., Athens  
Veale, Emory O., Arnoldsville  
Westbrook, R. J., Ila (Hon.)  
Whelchel, G. O., Athens  
Whitley, L. L., Athens

### CLAYTON-FAYETTE COUNTIES

#### Officers

President ..... Wallis, J. R.  
Vice-President ..... Coleman, Y. R.  
Secretary-Treasurer ..... Busey, T. J.  
Delegate ..... Coleman, Y. R.

#### Members

Busey, T. J., Fayetteville  
Coleman, Y. R., Jonesboro  
Robak, J. L., Jonesboro  
Wallis, J. R., Lovejoy

### COBB COUNTY

#### Officers

President ..... Perkinson, W. H.  
Vice-President ..... Lindley, F. P.  
Secretary-Treasurer ..... Welch, L. L.  
Delegate ..... Davis, E. S.  
Alternate Delegate ..... Fowler, R. W.  
Censor: McCall, M. N.

#### Members

Banister, C. D., Route 1, Marietta  
Colquitt, A. O., Jr., Marietta  
Crawley, Walter G., Marietta  
Davis, E. S., Acworth

Ellis, J. W., Kennesaw  
Fowler, A. H., Marietta  
Fowler, R. W., Marietta  
Garrett, Luke G., Austell  
Garrett, Luke G., Jr., Austell  
Hagood, G. F., Marietta  
Hagood, M. M., Marietta  
Harrison, W. B., Marietta  
Lester, J. E., Marietta  
Lindley, F. P., Powder Springs  
McCall, M. N., Acworth  
Mitchell, W. C., Smyrna  
Mussara, E. A., Marietta  
Perkinson, W. H., Marietta  
Teem, Martin Van B., Marietta  
Welch, L. L., Marietta

### COFFEE COUNTY

#### Officers

President ..... Quillian, B. O.  
Secretary-Treasurer ..... Johnson, R. L.  
Delegate ..... Harper, Sage  
Alternate Delegate ..... Jardine, Dan A.  
Censor: Clark, T. H.

#### Members

Clark, T. H., Douglas  
Lussell, J. K., Douglas  
Harper, Sage, Amrose  
Goodwin, H. J., Douglas  
Harris, Raymond, Ocilla  
Hembree, J. A., Pearson (Deceased)  
Jardine, Dan A., Douglas  
Johnson, R. L., Douglas  
McElroy, S. L., Ocilla  
Quillian, B. O., Douglas  
Shellhouse, L. H., Willacoochee  
Wallace, J. W., Douglas

### COLQUITT COUNTY

#### Officers

President ..... Joiner, R. M.  
Vice-President ..... McGinty, W. R.  
Secretary-Treas. .... Funderburk, A. G.  
Delegate ..... Woodall, J. B.  
Alternate Delegate ..... Joiner, R. M.  
Censors: Gay, F. M.; McGinty, W.  
R.; and Funderburk, A. G.

#### Members

Brannen, C. C., Moultrie  
Brannan, Cecil N., Moultrie  
Chesnutt, T. H., Moultrie  
Conger, Preston D., Moultrie  
Cumhie, Wm. Gary, Moultrie  
Daniel, Everett, Moultrie (Deceased)  
Funderburk, A. G., Moultrie  
Gay, F. M., Moultrie  
Joiner, R. M., Moultrie  
Lanier, J. E., Moultrie  
Lawson, E. L., Moultrie  
McCoy, John F., Moultrie  
McGinty, W. R., Moultrie  
Paulk, J. R., Moultrie  
Slocumb, C. B., Doerun  
Stegall, Robert E., U. S. Army  
Woodall, J. B., Moultrie  
Wright, J. J. C., Route 1, Rockmart

### COWETA COUNTY

#### Officers

President ..... Tanner, W. H.  
Secretary-Treasurer ..... Cochran, M. F.  
Delegate ..... Hammond, G. W.  
Delegate ..... Hammond, G. W.

### Members

Arnold, J. H., Newnan  
Cochran, M. F., Newnan  
Elliott, C. C., Sargent  
Hammond, G. W., Newnan  
Jackson, Bruce, Route 1, Newnan  
McDonald, R. H., Newnan  
Peniston, Joe B., Newnan  
St. John, Jas. O., Newnan  
Tanner, W. H., Route 2, Newnan  
Tribble, J. M., Senoia  
Woodroof, Wm. L., Newnan

### CRISP COUNTY

#### Officers

President ..... Williams, H. J.  
Vice-President ..... Adams, Charles  
Secretary-Treasurer ..... Whelchel, A. J.  
Delegate ..... Williams, P. L.

#### Members

Adams, Charles, Cordele  
Dorminy, J. N., Cordele (Hon.)  
Flournoy, H. C., Warwick  
Harwell, C. W., Cordele  
Hunt, G. M. D., Cordele (Hon.)  
McArthur, Chas. E., Cordele  
Whelchel, A. J., Cordele  
Williams, H. J., Cordele  
Williams, L. E., Cordele  
Williams, P. L., Cordele  
Wootten, L. O., Cordele

### DECATUR-SEMINOLE COUNTIES

#### Officers

President ..... Wilkinson, W. L.  
Vice-President ..... Whittle, Wm. E.  
Secretary-Treasurer ..... Ehrlich, M. A.  
Delegate ..... Wheat, R. F.  
Alternate Delegate ..... Willis, L. W.

#### Members

Alford, A. E. B., Bainbridge  
Baxley, Harry B., Donalsonville  
Bridges, C. E., Donalsonville  
Chason, Gordon, Bainbridge  
Ehrlich, M. A., Bainbridge  
Epps, George L., Bainbridge  
Fort, M. A., Bainbridge  
Moseley, E. E., Donalsonville  
Spooner, John I., Donalsonville  
(Hon.)  
Tucker, John P., Bainbridge  
Welch, Carl B., Attapulgus  
Wheat, R. F., Bainbridge  
Whittle, Wm. E., Iron City  
Wilkinson, W. L., Bainbridge  
Willis, L. W., Bainbridge

### DEKALB COUNTY

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Delegate..... Thompson, E. F.  
Alternate Delegate..... Crozier, G. T.  
Censors: Thomas, Frank; Mixon, J. F.; and Williams, T. Conrad.

#### Members

Bird, Ashley, U. S. Army (Asso.)  
Bird, Frank, Lake Park  
Burns, D. L., Valdosta  
Clements, H. W., Adel  
Crozier, G. T., Valdosta  
Eldridge, G. G., Valdosta  
Farbar, Marian E., Valdosta  
Giddens, C. C., Valdosta  
Giddens, I. S., Adel  
Hutchinson, L. R., Adel

Johnson, A. M., Valdosta  
Little, A. G., Valdosta  
Little, Alex G., Jr., Valdosta  
Mixon, J. F., Valdosta  
Mixon, Joyce F., Jr., Valdosta  
Oliphant, Jones B., Adel  
Owens, B. G., Valdosta  
Perry, Robert E., Jr., Valdosta  
Peters, James S., Jr., Nashville  
Quarterman, P. C., Valdosta  
Quillian, E. P., Clyattville  
Saunders, A. F., Valdosta  
Smith, E. J., Hahira  
Smith, J. R., Hahira  
Smith, T. H., Valdosta  
Stump, Robert L., Valdosta  
Thomas, F. H., Valdosta  
Thomas, Jos. A., Valdosta  
Thompson, E. F., Valdosta  
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Turner, W. W., Nashville  
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### MACON COUNTY

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Cheves, Langdon C., Jr., Montezuma  
Derrick, H. C., Oglethorpe  
Frederick, D. B., Marshallville  
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#### Member

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Bennett, Robert L., Warm Springs  
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Johnson, Edward G., Manchester  
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Vice-President..... Williams, M. W.  
Secretary-Treasurer..... Belcher, D. P.  
Delegate..... Brim, J. C.  
Alternate Delegate..... Williams, M. W.

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Brim, J. C., Pelham  
Burns, M. M., Pelham (Deceased)  
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Howard, C. L., Pelham  
 Knott, Arthur D., Camilla  
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 Delegate.....Alexander, G. H.

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 Bramblett, Augustus W., Jr., Forsyth  
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 Delegate.....Nicholson, J. H.  
 Alternate Delegate.....McGeary, W. C.

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 Vice-President.....Storey, W. E.  
 Secretary-Treasurer.....Wilson, J. M.  
 Delegate.....Walker, John E.  
 Alternate Delegate.....Jenkins, W. F.

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 Berman, Dave, Doctors Bldg.,  
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 Bickerstaff, H. J., Swift Bldg.,  
 Columbus  
 Blanchard, Mercer, 204 11th St.,  
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 Brannen, O. C., Murrah Bldg.,  
 Columbus  
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 Bush, John, 313 14th St., Columbus  
 Campbell, W. H., 1144 Broadway,  
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 Conner, Geo. R., 1229 2nd Ave.,  
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 Cooke, W. L., Doctors Bldg.,  
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 Columbus  
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 Bldg., Columbus  
 Edwards, Franklin D., 1344 2nd  
 Ave., Columbus  
 Freeman, Edward R., 313 14th St.,  
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 Gibson, R. L., Murrah Bldg.,  
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 Columbus  
 Jenkins, W. F., City Hospital,  
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 Columbus  
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 Columbus  
 Land, Polk S., 3440 Hamilton Ave.,  
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 Lapides, Leon, Swift Bldg.,  
 Columbus  
 Love, William G., 1312 3rd Ave.,  
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 Mayher, J. W., 1344 2nd Ave.,  
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 Mayher, W. E., 1344 2nd Ave.,  
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 McDuffie, J. H., Jr., 1120 3rd Ave.,  
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 McWhorter, M. R., 313 14th St.,  
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 Moses, Alice, 1413 2nd Ave.,  
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 Munn, E. K., Murrah Bldg.,  
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 Columbus  
 Peacock, C. A., Murrah Bldg.,  
 Columbus  
 Schley, Frank B., 303 11th St.,  
 Columbus  
 Spikes, J. L., Doctors Bldg.,  
 Columbus  
 Schuessler, George, 1437 2nd Ave.,  
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 Snelling, W. R., 1315 4th Ave.,  
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 Stapleton, J. L., 1130 5th Ave.,  
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 Storey, W. E., 1312 3rd Ave.,  
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 Tatum, P. A., Flowers Bldg.,  
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 Thompson, John B., Jr., Flowers  
 Bldg., Columbus  
 Thrash, J. A., 1310 Broadway,  
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 Threatte, Bruce, 204 11th St.,  
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 Wilson, J. M., Doctors Bldg.,  
 Columbus  
 Winn, J. H., Swift Bldg., Columbus  
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 Columbus  
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President.....Travis, W. D.  
 Secretary-Treas.....Mitchell, J. B., Jr.  
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 Alternate Delegate.....Huson, W. J.

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 Mitchell, J. B., Jr., Porterdale  
 Nesbit, F. C., Covington  
 Pitts, Julius T., Newborn  
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 Travis, W. D., Covington  
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 Secretary-Treas.....Smith, Richard, L.

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 Evans, A. P., Hawkinsville  
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 Jones, Edward Groves, Eastman  
 Long, H. W., Eastman  
 Massey, W. F., Chester  
 Mayo, J. Palmer, Eastman  
 Parkerson, I. J., Eastman  
 Smith, A. L., Cochran  
 Smith, J. M., Cochran  
 Smith, Richard L., Cochran  
 Thomson, James L., Eastman  
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 Vice-President.....

Spanger, Raymond F.

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 Delegate.....Styles, O. R.  
 Alternate Delegate.....Chaudron, P. O.

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 Cooper, J. J., Cedartown  
 Elliott, Cecil B., Cedartown  
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 Good, John W., Cedartown  
 Griffith, J. E., Rockmart  
 Hagan, James Howard, Rockmart  
 Lucas, W. H., Cedartown  
 McBryde, T. E., Rockmart  
 McGehee, John M., Cedartown  
 Ross, Grace R., Cedartown  
 Spanger, Raymond F., Cedartown  
 Styles, O. R., Cedartown  
 White, Geo. M., Rockmart  
 Whitely, Seals L., Cedartown  
 (Deceased)

**RABUN COUNTY****Officers**

President.....Dover, J. C.  
 Secretary-Treasurer.....Green, J. A.

Delegate.....Dover, J. C.  
 Alternate Delegate.....Green, J. A.

#### Members

Dover, J. C., Clayton  
 Green, J. A., Clayton

#### RANDOLPH-TERRELL

##### COUNTIES

##### Officers

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 Vice-President.....Smith, Chas R.  
 Secretary-Treas.....Elliott, W. G.  
 Delegate.....Sims, A. R.  
 Alternate Delegate.....Arnold, J. T.  
 Censors: Tidmore, Jos. C.; Rogers,  
 F. S.; and Sims, A. R.

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 Carter, George, Bluffton (Hon.)  
 Crook, W. W., Cuthbert  
 Elliott, W. G., Cuthbert  
 Gary, Loren, Georgetown  
 Harper, T. F., Coleman  
 Humber, J. W., Lumpkin  
 (Deceased)  
 Kenyon, J. M., Richland (Hon.)  
 Kenyon, Steve P., Dawson  
 Lewis, J. H., Dawson (Hon.)  
 Lunsford, J. F., Preston  
 Martin, F. M., Shellman  
 Martin, Robert B., III, Cuthbert  
 Martin, Walter B., Shellman  
 Patterson, J. C., Cuthbert  
 Rogers, F. S., Coleman  
 Saurez, Annette McD., Cuthbert  
 (Hon.)  
 Sims, A. R., Richland  
 Smith, Chas. R., 1236 Broadway,  
 Columbus  
 Tidmore, Jos. C., Dawson

#### RICHMOND COUNTY

##### Officers

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 Vice-President.....Thomas, D. R.  
 Secretary-Treasurer.....Harrell, H. P.  
 Delegate.....McGahee, R. C.  
 Alternate Delegate.....Thomas, D. R.  
 Censors: Harper, Harry T., Jr.;  
 Wright, Geo. W.; and Roule, J.  
 Victor.

##### Members

Agee, M. P., 753 Broad St., Augusta  
 Allen, Lane H., Medical College,  
 Augusta  
 Battey, Colden R., 921 Greene St.,  
 Augusta  
 Battey, W. W., Jr., 561 Telfair St.,  
 Augusta  
 Beard, B. C., 739 Greene St., Augusta  
 Bedingfield, W. R., Southern Finance  
 Bldg., Augusta  
 Bell, Jack E., 407 7th St., Augusta  
 Bernard, G. T., 203 13th St.,  
 Augusta  
 Bowen, J. B., Southern Finance  
 Bldg., Augusta  
 Brittingham, John W., 1345 Greene  
 St., Augusta  
 Brown, T. P., Marion Bldg., Augusta  
 Bryrans, C. I., 967 Meigs St.,  
 Augusta

Burdashaw, J. F., Johnson Bldg.,  
 Augusta  
 Burdshaw, Wm. J., 718 Monte Sano  
 Ave., Augusta  
 Butler, J. H., Southern Finance  
 Bldg., Augusta  
 Chaney, Ralph H., 1001 Greene St.,  
 Augusta  
 Clayton, M. D., Veterans Hospital,  
 Augusta  
 Cleckley, Hervey M., University  
 Hospital, Augusta  
 Coleman, Warren, 2749 Hillcrest,  
 Augusta (Hon.)  
 Corbitt, Melvis O., 1309 Holden St.,  
 Augusta  
 Davis, Abe J., 501 Greene St.,  
 Augusta  
 DeVaughn, N. M., Marion Bldg.,  
 Augusta  
 Fulghum, Thos E., Southern Finance  
 Bldg., Augusta  
 Fuller, Wm. A., 1345 Greene St.,  
 Augusta  
 Goodrich, W. H., 1345 Greene St.,  
 Augusta  
 Goodwin, T. W., Southern Finance  
 Bldg., Augusta  
 Gray, J. D., 1345 Greene St., Augusta  
 Greenblatt, Robert B., Medical  
 College, Augusta  
 Harper, Harry T., Jr., Marion Bldg.,  
 Augusta  
 Harrell, H. P., Southern Finance  
 Bldg., Augusta  
 Harrison, F. N., 407 7th St., Augusta  
 Henry, C. G., Southern Finance  
 Bldg., Augusta  
 Hensley, E. A., Gibson  
 Hitchcock, J. P., 561 Telfair St.,  
 Augusta  
 Hock, Chas. W., University Hospital,  
 Augusta  
 Holmes, L. P., Southern Finance  
 Bldg., Augusta  
 Jenkins, W. J., 921 Greene St.,  
 Augusta  
 Johnson, Robt. W., 1345 Greene St.,  
 Augusta  
 Jones, G. Frank, Jr., University  
 Hospital, Augusta  
 Kelly, G. Lombard, Medical College,  
 Augusta  
 Kennedy, F. A., 1345 Greene St.,  
 Augusta  
 Kilpatrick, A. J., 407 7th St.,  
 Augusta  
 Kilpatrick, Chas. M., Southern  
 Finance Bldg., Augusta  
 Klemann, G. L., 1345 Greene St.,  
 Augusta  
 Kupperman, H. S., University  
 Hospital, Augusta  
 Lee, F. Lansing, Southern Finance  
 Bldg., Augusta  
 Leonard, Robert E., 1001 Greene St.,  
 Augusta  
 Levy, M. S., Battey State Hospital,  
 Rome

Lewis, S. J., Southern Finance Bldg.,  
 Augusta  
 Major, Robert C., University  
 Hospital, Augusta  
 Massengale, Leonard R., University  
 Hospital, Augusta  
 Mathews, Marion, Marion Bldg.,  
 Augusta  
 Mathews, W. E., Southern Finance  
 Bldg., Augusta  
 McDaniel, J. Z., Citizens & Southern  
 Bank Bldg., Albany  
 McGahee, R. C., 1345 Greene St.,  
 Augusta  
 McGinty, H. C., Shirley Apts.,  
 Augusta  
 Mealing, Henry G., Southern Finance  
 Bldg., Augusta  
 Mettler, Fred A., Columbia Univer-  
 sity College of Physicians and Sur-  
 geons, New York, N. Y.  
 Michel, H. M., University Hospital,  
 Augusta  
 Miller, Abraham, 314 Broad St.,  
 Augusta  
 Miller, Harold A., Fidelity Trust Co.  
 Bldg., Pittsburg, Pa.  
 Miller, John M., University Hospital,  
 Augusta  
 Milligan, K. W., 942 Greene St.,  
 Augusta  
 Mountain, G. W., 1121 Monk Sound,  
 Augusta  
 Mulherin, Chas. M., 1211 Greene St.,  
 Augusta  
 Mulherin, F. X., 1001 Greene St.,  
 Augusta  
 Mulherin, Philip A., 1211 Greene St.,  
 Augusta  
 Murphey, E. E., 432 Telfair St.,  
 Augusta  
 Norvell, J. T., 1240 Greene St.,  
 Augusta  
 Persall, John T., Jr., Southern  
 Finance Bldg., Augusta  
 Philpot, W. K., 1345 Greene St.,  
 Augusta  
 Phinizy, Irvine, Southern Finance  
 Bldg., Augusta  
 Phinizy, Thomas, 1345 Greene St.,  
 Augusta  
 Price, W. T., Leonard Bldg., Augusta  
 Pund, Edgar R., Medical College,  
 Augusta  
 Rhodes, R. L., Southern Finance  
 Bldg., Augusta  
 Rinker, J. Robert, Medical College,  
 Augusta  
 Risteen, W. A., University Hospital,  
 Augusta  
 Roberts, W. H., 828 Greene St.,  
 Augusta  
 Roule, J. Victor, Southern Finance  
 Bldg., Augusta  
 Sanderson, E. S., Medical College,  
 Augusta  
 Sanford, Dudley Phelps, Southern  
 Finance Bldg., Augusta  
 Scharnitzky, E. O., 1262 Greene St.,  
 Augusta



Sherman, John H., University Hospital, Augusta  
 Schmidt, Henry L., Medical College, Augusta  
 Silver, D. M., Southern Finance Bldg., Augusta  
 Sydenstricker, V. P., University Hospital, Augusta  
 Templeton, C. M., Southern Finance Bldg., Augusta  
 Tessier, Claude E., Masonic Bldg., Augusta  
 Thomas, D. R., Southern Finance Bldg., Augusta  
 Thurmond, A. G., 623 Greene St., Augusta  
 Thurmond, J. W., 407 7th St., Augusta  
 Timmons, C. C., 415 Milledge Rd., Augusta  
 Todd, L. N., University Hospital, Augusta  
 Torpin, Richard, Medical College, Augusta  
 Volpitta, Perry P., University Hospital, Augusta  
 Ward, C. D., 1345 Greene St., Augusta  
 Weeks, J. L., Harlem  
 Weeks, R. B., Southern Finance Bldg., Augusta  
 Wilcox, E. A., 1345 Greene St., Augusta  
 Wilkes, W. A., University Hospital, Augusta  
 Williams, W. J., Southern Finance Bldg., Augusta  
 Willis, C. H., Southern Finance Bldg., Augusta  
 Woodbury, Robert A., Medical College, Augusta  
 Wright, Geo. W., 1345 Greene St., Augusta  
 Wright, P. B., 1345 Greene St., Augusta

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 Delegate Griggs, Harvey E.  
 Alternate Delegate Brown, P. J.

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Brown, P. J., Conyers  
 Griggs, Harvey E., Conyers

**SCREVEN COUNTY****Member**

Bennett, W. H., Sylvania

**SPALDING COUNTY****Officers**

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 Vice-President Smaha, T. G.  
 Secretary-Treasurer Vinson, T. O.  
 Delegate Smaha, T. G.  
 Alternate Delegate Floyd, Thos. J.

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 Barfield, Wm. E., Jackson  
 Cagle, W. D., Battey State Hospital, Rome  
 Copeland, H. J., Griffin  
 Copeland, H. W., Griffin  
 English, R. E. L., Griffin

Floyd, T. J., Jr., Griffin  
 Forrer, D. A., Griffin  
 Frye, A. H., Griffin  
 Giles, J. T., Griffin  
 Grubbs, J. H., Molena  
 Frye, Augustus H., Jr., Griffin  
 Hammond, Robert L., Jackson  
 Hawkins, T. I., Griffin (Deceased)  
 Head, D. L., Zebulon  
 Head, M. M., Zebulon  
 Howard, I. B., Williamson  
 Hunt, Kenneth H., Griffin  
 Ingram, Starr, Doctors Hospital, East End Ave. at 87th St., New York, N. Y.  
 Jones, Alex P., Griffin  
 Miles, W. C., Griffin  
 Perkins, H. R., Griffin  
 Smaha, T. G., Griffin  
 Stuckey, Ann, Griffin  
 Vinson, T. O., Griffin  
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 Vice-President Sapp, J. C.  
 Secretary-Treasurer Ayers, C. L.  
 Delegate Sapp, J. C.  
 Alternate Delegate Terrell, J. H.  
 Censors: Good, W. H., Jr.; Ayers, S. E.; and Chaffin, E. F.

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 Ayers, S. E., Toccoa  
 Chaffin, E. F., Toccoa  
 Edge, J. H., Toccoa (Hon.)  
 Good, W. H., Jr., Toccoa  
 Heller, W. B., Toccoa (Hon.)  
 Isbell, J. E. D., Toccoa  
 Sapp, C. J., Rome  
 Schaefer, W. Bruce  
 Terrell, J. H., Toccoa

**SUMTER COUNTY****Officers**

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 Vice-President Logan, J. C.  
 Secretary-Treasurer Enzor, R. H.  
 Delegate Pendergrass, R. C.  
 Alternate-Delegate Boyette, L. S.

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 Boyette, L. S., Ellaville  
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 Enzor, R. H., Smithville  
 Fenn, Henry R., Americus  
 Gatewood, T. Schley, Americus  
 Logan, J. Colquitt, Plains  
 Pendergrass, R. C., Americus  
 Primrose, A. C., Americus  
 Robinson, John H., III, Americus  
 Smith, Herschel A., Americus  
 Stukes, J. T., Americus  
 Thomas, Russell B., Americus  
 Wise, B. J., Americus (Hon.)  
 Wood, Kenneth, Leslie

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 Vice-President Jelks, L. R.

Secretary-Treasurer Hughes, J. M.  
 Delegate Strickland, L. V.  
 Censor: Colson, A. C.

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 Colson, A. C., Glennville  
 Hughes, J. M., Glennville  
 Jelks, L. R., Reidsville  
 McCarver, W. C., Jr., Glennville  
 Strickland, L. V., Cobbtown  
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**TAYLOR COUNTY****Officers**

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 Vice-President Bryan, S. H.  
 Secretary-Treas. Montgomery, R. C.  
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 Bryan, S. H., Reynolds  
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 Vice-President Maloy, C. J.  
 Secretary-Treasurer Mann, Frank R.  
 Delegate Parkerson, S. T.  
 Alternate Delegate Maloy, C. J.  
 Censors: Born, W. H.; Parkerson, S. T.; and Maloy, C. J.

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Born, W. H., McRae  
 Maloy, C. J., McRae  
 Mann, Frank R., McRae  
 Parkerson, S. T., McRae

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 Vice-President Mobley, John  
 Secretary-Treas. Erickson, Mary J.  
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 Bell, Rudolph F., Thomasville  
 Bellhouse, Helen, Thomasville  
 Collins, J. J., Thomasville  
 Daniel, Frank C., Pavo  
 Dillinger, George R., Thomasville  
 Erickson, Mary J., Thomasville  
 Ferguson, C. H., Thomasville (Deceased)  
 Futch, Thomas A., Jr., Thomasville  
 Garrett, J. A., Meigs  
 Harner, Joseph W., Jr., Thomasville  
 Isler, J. N., Meigs  
 Jarrell, W. W., Thomasville  
 King, J. T., Thomasville  
 Little, A. D., Thomasville  
 Lundy, L. L., Boston  
 Mobley, John, Thomasville  
 Moore, H. M., Thomasville  
 Palmer, J. I., Thomasville  
 Readling, Herbert F., Thomasville  
 Reid, James W., Thomasville  
 Sanchez, S. E., Barwick (Deceased)  
 Sanchez, S. E., Jr., Barwick  
 Shepard, Kirk, Thomasville  
 Wahl, Ernest F., Thomasville  
 Wall, C. K., Thomasville

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 Vice-President Zimmerman, Chas. E.  
 Secretary-Treasurer.....Pittman, C. S.  
 Delegate.....Hendricks, W. H.

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 Andrews, Ella F., Tifton  
 Evans, E. L., Tifton  
 Fleming, Carlton A., Tifton  
 Harrell, D. B., Tifton  
 Hendricks, W. H., Tifton  
 Jones, R. E., Tifton  
 LeRoy, Albert G., Southern Finance  
   Bldg., Augusta  
 Pickett, F. B., Ty Ty  
 Pittman, C. S., Tifton  
 Shaw, M. F., Omega  
 Webb, M. L., Tifton  
 Zimmerman, Chas. E., Tifton  
 Zimmerman, W. F., Tifton

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Secretary-Treasurer.....Aiken, W. W.

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 Goss, O. S., Vidalia  
 Mercer, J. E., Vidalia

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 Vice-President.....Sharp, C. K.  
 Secretary-Treasurer.....Standifer, J. G.  
 Delegate ..... Standifer, J. G.  
 Alternate Delegate ..... Hays, W. C.

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 Baughn, E. B., Colquitt  
 Baxley, W. C., Blakely  
 Beard, J. S., Edison  
 Bridges, R. R., Leary  
 Hattaway, J. C., Edison  
 Hays, W. C., Colquitt  
 Holland, S. P., Blakely  
 Merritt, J. W., Colquitt  
 Sharp, C. K., Arlington  
 Sharp, C. M., Florida  
 Shepard, J. L., Damascus  
 Shepard, W. O., Bluffton  
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**NEWS ITEMS**

Official call to the officers, fellows and members of the American Medical Association: The supplemental session of the House of Delegates of the American Medical Association was held in Chicago, Ill., from December 9-11, 1946. Dr. Allen H. Bunce, Atlanta; Dr. Olin H. Weaver, Macon; Dr. B. H. Minchew, Waycross; Dr. C. W. Roberts and Dr. Edgar D. Shanks, both of Atlanta, represented the Medical Association of Georgia at the meeting.

\* \* \*

The Bibb County Medical Society held its regular meeting at the New Yorker Cafe, Macon, November 5. Program: "Rocky Mountain Spotted Fever," Dr. T. F. Sellers, Atlanta

\* \* \*

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton St., Savannah, November 12. Subject: "Bone Graft Surgery—Lantern Slides," by Dr. T. A. Peterson.

\* \* \*

Dr. A. S. Johnson, Jr., Elberton, announces his release

from the Medical Corps of the U. S. Army and his association with his father, Dr. A. S. Johnson, for the practice of medicine at Elberton.

\* \* \*

Dr. Carl S. Pittman, Jr., Tifton, recently returned from the Cook County Graduate School of Medicine, Chicago, where he took a 6 weeks' post-graduate course. Dr. Pittman was recently released from the Medical Corps of the U. S. Army, having served two years, is now associated with his father, Dr. C. S. Pittman, Tifton, for the general practice of medicine and surgery.

\* \* \*

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton St., Savannah, November 26. Program: "Russia and the Communist International", address by Mr. T. M. Cunningham.

\* \* \*

Dr. George M. Ricketson, formerly of Broxton, recently released from the U. S. Navy Medical Corps, announces his association with Dr. T. H. Clark, Douglas, for the practice of medicine.

Dr. W. H. Good, Toccoa, announces his association with Dr. Arthur G. Singer, Jr., for the practice of internal medicine and roentgenology, Terrell Building, Toccoa.

\* \* \*

Dr. John M. Snelling, Jr., formerly of Augusta, recently discharged from the Medical Corps of the U. S. Navy, has opened offices for the practice of medicine at Ashburn.

\* \* \*

Dr. T. M. Spruell, Temple, celebrated his 79th birthday at the home of his son, Mr. Roy Spruell, North Highland Ave., Atlanta, October 13. Dr. Spruell has been practicing medicine at Temple for the past 54 years and is still active.

\* \* \*

Dr. James B. Traylor, formerly of Augusta, announces his association with Dr. M. W. Anderson, Social Circle, for the practice of medicine.

\* \* \*

Dr. Lawson Thornton and Dr. Philip Warner, Atlanta, announce their association in the practice of orthopedic surgery, 478 Peachtree St., N.E., Atlanta.

\* \* \*

Dr. Marvin B. Wine, Thomasville, recently discharged from the military service, announce the opening of offices at 109 N. Crawford St., Thomasville. Practice limited to asthma, hay fever and other allergic diseases.

\* \* \*

The Third District Medical Society held its fall meeting at the community clubhouse, Dawson, November 22. The Randolph-Terrell Medical Society was host. Call to order by the president, Dr. W. P. Jordon, Columbus; Invocation, Rev. J. L. Hillis, pastor, First Methodist Church; Address of welcome, Hon. Ed Stevens, mayor of Dawson; Response to address of welcome, Dr. Chas. E. McArthur, Cordele. Scientific Program: "Cervical Pathology Amenable to Office Treatment", Dr. Edgar H. Greene, Atlanta; "The Use of Biologicals in Prophylaxis and Therapeutics in Pediatrics", Dr. Roger W. Dickson, Atlanta; "Recent Developments in the Treatment of Thyroid Disease", Dr. David Henry Poer, Atlanta; "The Management of Elbow Injuries", Dr. Calvin Sandison, Atlanta; "The Management of Coronary Disease", Dr. Charles F. Stone, Atlanta; Report of Councilor, Dr. W. G. Elliott, Cuthbert.

The Woman's Auxiliary of the Third District Medical Society met at Terrell House, Dawson.

\* \* \*

Dr. R. A. Woodbury, chairman of the Committee on Scientific Exhibit of the Medical Association of Georgia, desires immediate consideration of the exhibits for the 1947 annual session of the Association, which will be held at the Bon Air Hotel, Augusta, April 22-25. Members and others desiring to have scientific exhibits should communicate with Dr. Woodbury immediately, at the Medical School, Augusta, or with the Secretary-Treasurer, Dr. Edgar Shanks, 478 Peachtree St., N.E., Atlanta.

\* \* \*

Dr. T. H. Clark, Douglas, president, and Dr. Murdock Equen, Atlanta, vice-president, are new officers of the State Board of Medical Examiners of Georgia.

\* \* \*

Dr. R. M. Moore, Waleska, now aged 83 and a practitioner of medicine in his community for 61 years, was honored recently by having the story of his life and medical contributions portrayed in the magazine section of the *Atlanta Journal*. Dr. Moore has long been an active member of the Cherokee-Pickens Medical Society.

\* \* \*

Dr. J. M. Barnett, Albany, also was honored recently by the magazine section of the *Atlanta Journal*. The story depicted Dr. Barnett's interest both in medicine and in farming. At one of his farms in Dougherty County his planning and work have resulted in better yields in crops, and in marked improvement in public health measures for the community in which this farm is located.

The Laurens County Medical Society and the medical staff of Dublin Naval Hospital meetings were held jointly at the hospital, November 21. The program was confined to a discussion of rheumatic fever. Participating were: Drs. J. B. Logue, M. W. Webb, J. R. Seal, H. G. Nelson, R. L. Bailey, J. B. Black, and C. S. Oliver.

#### OBITUARY

Dr. Joseph Alonzo Brown, aged 77, Shady Dale, prominent physician and citizen of Jasper County, died suddenly in his office, October 18, 1946. Dr. Brown was born in Walton County where he attended the public schools, then the University of Georgia, Athens, and later Emory College at Oxford. He graduated from the University of Georgia School of Medicine, Augusta, in 1891. He practiced medicine at Buckhead, Social Circle, Eastman and moved to Shady Dale in 1909. He was a member of the Jasper County Medical Society, the Medical Association of Georgia, and was a fellow of the American Medical Association. At the time of his death he was clerk of the Providence Baptist Church and a member of the Walton Lodge of Masons. He served as trustee of the Shady Dale School, of the city council, and also as mayor. He is survived by his wife, the former Miss Mamie Martin; one nephew, Shivers Brown, Philadelphia, Pa., and a niece, Mrs. Dan Stanbaugh, Demorest. Funeral services were held at the Providence Baptist Church, Shady Dale, with the Rev. J. S. Hays officiating. Burial was in the City Cemetery, Eastman.

\* \* \*

Dr. Grady Lumsden Carter, aged 56, retired prominent Talbotton physician, died at his home after a long illness, October 15, 1946. Dr. Carter was born in Talbot County, the son of the late Mr. and Mrs. John Allen Carter. He graduated from the Atlanta School of Medicine, now Emory University School of Medicine, Atlanta, in 1913, and began the practice of medicine at Talbotton. He served as the typical country doctor, being known as "Dr. Grady". He was most unselfish and generous in all cases, giving of his best at all times. He was a member of the Talbotton Methodist Church. Surviving are his wife, Mrs. Ruth Arnold Carter; two sons, Hugh P. Carter, Birmingham, and Norman K. Carter, Talbotton; two grandchildren, Norman K. Carter, Jr., Talbotton, and Lynne Carter, Birmingham. Funeral services were held at the home, with the Rev. C. W. Jordan and the Rev. Theo Pharr officiating. Burial was in Oak Hill Cemetery, Talbotton.

\* \* \*

Dr. Joseph Krafka, Jr., aged 50, Augusta, died at an Augusta infirmary after an illness of several months, November 5, 1946. Dr. Krafka was born at Ottumwa, Iowa. He graduated from the University of Georgia School of Medicine, Augusta, in 1933. Since 1926 Dr. Krafka had been professor of Microscopic Anatomy and head of that department in the University of Georgia School of Medicine. From 1919 to 1926 he was professor of Zoology and head of that department at the University of Georgia, Athens. He was instrumental in the founding of the Georgia Academy of Science and, in addition, was a member of the following national associations: American Society of Zoologists, Entomological Society of America, American Association of Anatomists, and Sigma XI, honorary science fraternity. He was listed in "American Men of Science" and "Who's Who in America".

In addition to being an inspiring teacher, Dr. Krafka was a zealous research worker and published scores of original articles dealing with research in his chosen field in anatomy, and also in the history of medicine, in which he was particularly interested. He was one of the best known authorities on the medical history of Georgia. He was also the author of two widely used textbooks, one on histology and the other on embryology. Dr. Krafka is survived by his widow, the former Miss Bessie Harsch; a daughter, Mrs. Norman Freeman, LaGrange; and a son, Dr. Joseph Franklin Krafka, Augusta; four sisters, two brothers and two grandchildren. Funeral services were held at Platt's Chapel, Augusta, with the Rev. J. S. Thrailkill officiating. Burial was at Ottumwa, Iowa.



# The Journal *of the* Medical Association of Georgia

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January-December, 1946

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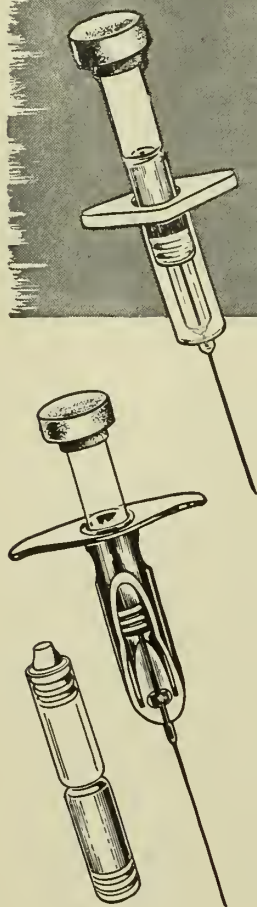
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